



*Communications  
Workers of America*

*The Connecticut Union  
of  
Telephone Workers, Inc.*



*Local 1298*  
AFL-CIO

3055 Dixwell Avenue • Hamden, CT 06518 • (203) 288-5271 • Toll Free (800) 833-2889

## **HEALTHCARE COSTS, DEDUCTIBLES & OUT OF POCKET MAXIMUMS**

August, 2019

Due to internal system issues at Anthem & Beacon, employee deductibles were applied toward out of pocket maximums in error. As outlined in our healthcare SPD, deductibles are not included in out of pocket max calculation. (see attached)

To remedy this issue, the carriers have audited their systems and made the appropriate recalculations for employees who have been affected by the error.

Additionally, Anthem failed to update their systems to reflect the increase in out of pocket max during previous years. This was identified mid-year in 2019. For 2019, the correct amounts have now been updated. Out of pocket max for employees should have increased in 2016, from \$1700/\$3400 to \$2000/\$4000. This change has now been implemented and will be in effect for 2019.

Attachments include copy of MOU agreed upon in 2014 outlining employee responsibilities for deductibles and out of pocket max for the years of 2014, 2015, 2016. There have been no changes beyond what is outlined in the MOU.

Also attached are excerpts from health insurance SPD's for 2019, 2018, 2017, 2016. There has been no change to the SPD language outlining that deductibles are not included in calculating out of pocket max.

Detailed benefit information can be accessed at [www.frontierbenefitscenter.com](http://www.frontierbenefitscenter.com)

SPD's can also be accessed at [www.cwa1298.org](http://www.cwa1298.org)

Specific questions can directed to the benefits office @ (203)288-5271

East Core CWA Benefits Outline Summary

Exhibit 1

KZ  
04/11

Provision	Current Employees, 2009 New Hires and 2012 New Hires																																									
Urgent Care Facility/Professional Services Copay / Coinsurance	2012 New Hires, 2009 New Hires and Current Employees No change from current plan.																																									
Emergency Room Facility/Professional Services Copay / Coinsurance	2012 New Hires, 2009 New Hires and Current Employees No change from current plan.																																									
Hospital Inpatient/Outpatient Facility/Professional Services Copay / Coinsurance	2012 New Hires, 2009 New Hires and Current Employees No change from current plan.																																									
Tests (all tests including x-ray, radiology, lab test, etc) CoPay/ Coinsurance	2012 New Hires, 2009 New Hires and Current Employees No change from current plan.																																									
Mental Health/Substance Abuse (MH/SA) Copay / Coinsurance	2012 New Hires, 2009 New Hires and Current Employees No change from current plan.																																									
<b>Annual Out-of-Pocket Maximums (OOP)</b>	<p>2012 New Hires, 2009 New Hires and Current Employees</p> <p style="text-align: center;"><b>Out-of-Pocket Maximum Amounts (excluding Annual Deductible)</b></p> <table border="1"> <thead> <tr> <th></th> <th>2014</th> <th>2014</th> <th>2015-2016</th> <th>2015-2016</th> </tr> <tr> <th></th> <th>Network, PPO &amp; ONA</th> <th>Non-Network &amp; Non-PPO</th> <th>Network, PPO &amp; ONA</th> <th>Non-Network &amp; Non-PPO</th> </tr> </thead> <tbody> <tr> <td>Ind</td> <td>\$1,700</td> <td>\$ 5,100</td> <td>\$2,000</td> <td>\$ 6,000</td> </tr> <tr> <td>Fam</td> <td>\$3,400</td> <td>\$10,200</td> <td>\$4,000</td> <td>\$12,000</td> </tr> </tbody> </table> <p>Out-of-Pocket Maximum provisions: No change from current plan</p>		2014	2014	2015-2016	2015-2016		Network, PPO & ONA	Non-Network & Non-PPO	Network, PPO & ONA	Non-Network & Non-PPO	Ind	\$1,700	\$ 5,100	\$2,000	\$ 6,000	Fam	\$3,400	\$10,200	\$4,000	\$12,000																					
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<b>Prescription Drug Program (Rx)</b>	<p>2012 New Hires, 2009 New Hires and Current Employees</p> <p><b>Deductible:</b> None.</p> <p><b>Out-of-Pocket Maximum:</b></p> <table border="1"> <thead> <tr> <th></th> <th>2014-2015</th> <th>2016</th> </tr> </thead> <tbody> <tr> <td>Ind</td> <td>\$ 900</td> <td>\$1,200</td> </tr> <tr> <td>Fam</td> <td>\$1,800</td> <td>\$2,400</td> </tr> </tbody> </table> <p><b>Retail – Network Copays:</b> (Up to 30-day supply, limited to 2 fills for maintenance)</p> <table border="1"> <thead> <tr> <th></th> <th>2014</th> <th>2015</th> <th>2016</th> </tr> </thead> <tbody> <tr> <td>Generic</td> <td>\$10</td> <td>\$10</td> <td>\$10</td> </tr> <tr> <td>Formulary</td> <td>\$20</td> <td>\$30</td> <td>\$35</td> </tr> <tr> <td>Non-Formulary</td> <td>\$40</td> <td>\$60</td> <td>\$60</td> </tr> </tbody> </table> <p>Retail – Non-Network Copays: Participant pays the greater of the applicable Network copay or balance remaining after the plan pays 75% of network retail cost.</p> <p><b>Mail Order Copays:</b> (Up to 90-day supply)</p> <table border="1"> <thead> <tr> <th></th> <th>2014</th> <th>2015</th> <th>2016</th> </tr> </thead> <tbody> <tr> <td>Generic</td> <td>\$20</td> <td>\$ 20</td> <td>\$ 20</td> </tr> <tr> <td>Formulary</td> <td>\$40</td> <td>\$ 60</td> <td>\$ 70</td> </tr> <tr> <td>Non-Formulary</td> <td>\$80</td> <td>\$120</td> <td>\$120</td> </tr> </tbody> </table> <p><b>The following provisions will continue to apply:</b></p> <ul style="list-style-type: none"> <li>• Mandatory mail order for maintenance Rx – Applies after second fill at retail.</li> <li>• Specialty pharmacy program</li> <li>• Personal Choice – 100% participant-paid</li> <li>• Mandatory Generic</li> </ul>		2014-2015	2016	Ind	\$ 900	\$1,200	Fam	\$1,800	\$2,400		2014	2015	2016	Generic	\$10	\$10	\$10	Formulary	\$20	\$30	\$35	Non-Formulary	\$40	\$60	\$60		2014	2015	2016	Generic	\$20	\$ 20	\$ 20	Formulary	\$40	\$ 60	\$ 70	Non-Formulary	\$80	\$120	\$120
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<b>Employee Assistance Program (EAP)</b>																																										
Plan	2012 New Hires, 2009 New Hires and Current Employees No change from current plan except for name change eff. 2 <sup>nd</sup> qtr 2013 to AT&T Employee Assistance Program.																																									
Visit Limit	2012 New Hires, 2009 New Hires and Current Employees																																									

# Summary Plan Description

IMPORTANT BENEFITS INFORMATION

## FRONTIER COMMUNICATIONS CORPORATION CWA 1298 EMPLOYEE MEDICAL PROGRAM

(formerly referred to as "East Bargained")

(Health Care Network Option)

*This is a summary plan description (SPD) for the CWA 1298 Employee Medical Program, a component program under the Frontier Communications Corporation Health Care Plan, Plan 505. This SPD replaces the prior Medical SPD for the Health Care Network Option and all of its summaries of material modifications. Please keep this SPD for future reference.*

Medical

Summary Plan Description/January 2019

PK 094-HCN  
PK 095- HCN/ONA

If you change from Individual coverage to Individual + 1 or Individual + 2 or more during the year, see the section called "Impact of a Midyear Change in Coverage on the Annual Deductible and Annual Out-of-Pocket Maximum."

### Coinsurance

Coinsurance is the percentage of Allowable Charges you pay for Covered Health Services except Network Preventive Health Services.

The Coinsurance percentage varies depending on the Covered Health Service. For Covered Health Services that are subject to a Network requirement, the Coinsurance percentage also varies, depending on whether or not you use a Network Provider.

If you use a Provider who charges more than the Allowable Charge for a Covered Health Service, you also will be responsible for any charges in excess of the Allowable Charge.

*This is an example only. The actual coinsurance percentage, such as the applicable coinsurance percentage, will depend on your situation. The coinsurance amount for your charges is not the only cost you pay.*

*The example in this section shows the amount of Allowable Charges if you use a Network Provider and the amount if you use a Non-Network Provider and you use a Network Provider for a Covered Health Service, the Network Provider (also called a Participating Provider) and a Non-Network Provider (also called a Non-Participating Provider). For example, for a procedure with an Allowable Charge of \$1,000, you would pay \$300 (30% coinsurance) if you use a Network Provider and \$1,000 (100% coinsurance) if you use a Non-Network Provider. In this example, the coinsurance amount is based on the Allowable Charge of \$1,000. If you use a Network Provider, the coinsurance amount is based on the Allowable Charge of \$1,000. If you use a Non-Network Provider, the coinsurance amount is based on the Allowable Charge of \$1,000. If you use a Network Provider, the coinsurance amount is based on the Allowable Charge of \$1,000. If you use a Non-Network Provider, the coinsurance amount is based on the Allowable Charge of \$1,000.*

### Annual Out-of-Pocket Maximum

The Annual Out-of-Pocket Maximum limits the amount you pay for Covered Health Services each year. Once your payments for Covered Health Services reach the applicable Annual Out-of-Pocket Maximum, the Program pays 100 percent of any Allowable Charges for most Covered Health Services for the rest of the year, unless you change your Program option. See the section called "Impact of a Midyear Change in Coverage on the Annual Deductible and Annual Out-of-Pocket Maximum."

**Please Note:** Notwithstanding that the Annual Out-of-Pocket Maximum limits for the Program do not include the Annual Deductible, the Network Allowable Charges for Eligible Expenses you pay out of pocket for a calendar year (including the deductible) for Covered Health Services (including Prescription Drugs) may not exceed the limit specified for each year by the Affordable Care Act (\$7,900 for single coverage and \$15,800 for all other dependent tiers in 2019).

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### **Coinsurance**

Coinsurance is the percentage of Allowable Charges you pay for Covered Health Services except Network Preventive Health Services.

The Coinsurance percentage varies depending on the Covered Health Service. For Covered Health Services that are subject to a Network requirement, the Coinsurance percentage also varies, depending on whether or not you use a Network Provider.

If you use a Provider who charges more than the Allowable Charge for a Covered Health Service, you also will be responsible for any charges in excess of the Allowable Charge.

*This is an example only. The actual terms of your Program, such as the applicable Coinsurance amounts, will govern; you can substitute the coinsurance amounts for your Program to see how this could affect you.*

For example, if the Program pays 90 percent of Allowable Charges if you use a Network Provider and 60 percent if you use a Non-Network Provider and you visit a Network Provider for a Covered Health Service, the Network Provider will accept a Negotiated Rate. If the Negotiated Rate is \$10,000 and you have met your Annual Deductible, the Program will pay \$9,000 (90% x \$10,000). You will be responsible for the \$1,000 coinsurance amount (10% x \$10,000).

If you visit a Non-Network Provider, the Provider's billed charge may be higher than the Allowable Charge. If the Allowable Charge is \$10,000, the Provider bills \$14,000, and you have met your Annual Deductible, the Program will pay \$6,000 (60% x \$10,000). You will be responsible for the \$4,000 coinsurance amount (40% x \$10,000) plus the remaining \$4,000 difference between the amount billed (\$14,000) and the Allowable Charge (\$10,000).

**Note:** If you are enrolled in a coverage option that does not pay Benefits differently based on whether you use a Network Provider, the Program will pay the same percent of Allowable Charges whether you use a Network Provider or not. However, if you use a Network Provider, your Coinsurance amount will be based on the Negotiated Rate and, because the Network Provider accepts the Negotiated Rate as payment for the Covered Health Services, you will not be responsible for the difference between the amount billed and the Allowable Charge.

### **Annual Out-of-Pocket Maximum**

The Annual Out-of-Pocket Maximum limits the amount you pay for Covered Health Services each year. Once your payments for Covered Health Services reach the applicable Annual Out-of-Pocket Maximum, the Program pays 100 percent of any Allowable Charges for *most* Covered Health Services for the rest of the year, unless you change your Program option. See the section called "Impact of a Midyear Change in Coverage on the Annual Deductible and Annual Out-of-Pocket Maximum."

**Please Note:** Notwithstanding that the Annual Out-of-Pocket Maximum limits for the Program do not include the Annual Deductible, the Network Allowable Charges for Eligible Expenses you pay out of pocket for a calendar year (including the deductible) for Covered Health Services (including Prescription Drugs) may not exceed the limit specified for each year by the Affordable Care Act (\$7,350 for single coverage and \$14,700 for all other dependent tiers in 2018).

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### **Coinsurance**

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The Coinsurance percentage varies depending on the Covered Health Service. For Covered Health Services that are subject to a Network requirement, the Coinsurance percentage also varies, depending on whether or not you use a Network Provider.

If you use a Provider who charges more than the Allowable Charge for a Covered Health Service, you also will be responsible for any charges in excess of the Allowable Charge.

*This is an example only. The actual terms of your Program, such as the applicable coinsurance amounts, will determine your actual coinsurance amounts for your Program. In each of the following examples, the Program pays 60 percent of Allowable Charges if you use a Network Provider and 60 percent if you use a Non-Network Provider and you visit a Network Provider for a Covered Health Service. The Network Provider will receive the Negotiated Rate. If the Negotiated Rate is \$10,000 and you have met your Annual Deductible, the Program will pay \$9,000 (90% x \$10,000). You will be responsible for the \$1,000 coinsurance amount (10% x \$10,000).*

*If you visit a Non-Network Provider, the Provider's billed charge is in violation of the Allowable Charge. If the Allowable Charge is \$10,000, the Provider bills \$11,000 and you have met your Annual Deductible, the Program will pay \$9,000 (60% x \$10,000). You will be responsible for the \$2,000 coinsurance amount (20% x \$10,000) plus the remaining \$1,000 difference between the amount billed (\$11,000) and the Allowable Charge (\$10,000).*

*Not all of our enrolled health coverage options that do not pay benefits differently based on whether you use a Network Provider. The Program will pay the same percent of Allowable Charge whether you use a Network Provider or not. However, if you use a Non-Network Provider, your coinsurance amount will be based on the Negotiated Rate and, because the Network Provider receives the Negotiated Rate as payment for the Covered Health Service, you will not be responsible for the difference between the amount billed and the Allowable Charge.*

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# Summary Plan Description

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