CENTRAL PENNSYLVANIA TEAMSTERS
HEALTH & WELFARE FUND
PLAN 14

Summary of Material Modification
October 2011

Important changes to your benefits! Please read carefully.

THE FOLLOWING CHANGES
WILL GENERALLY BE EFFECTIVE FOR TREATMENT AND SERVICES RECEIVED ON OR AFTER JANUARY 1, 2012

This notice includes both information about (A) benefit improvements that will be implemented effective January 1, 2012 in order to comply with the Patient Protection and Affordable Care Act ("PPACA"), which is often referred to generally as the Health Care Reform Act, (B) newly implemented copayments for certain services, and (C) changes to the eligibility requirements for retiree coverage.

A. AFFORDABLE CARE ACT CHANGES:

1. **Enrolling Adult Children Up to Age 26.** You may enroll your eligible dependent child up to age 26, even if that child has coverage available through his or her employer;

2. **Pre-Existing Condition Exclusions.** No pre-existing condition exclusions will be applied to you or to any of your eligible dependents;

3. **Preventive Care Services including Immunizations.** The PPACA requires coverage of specified preventive services and prohibits cost-sharing for those services. The preventive services included in this mandate are only those "A" or "B" recommendations of the United States Preventive Services Task Force, Advisory Committee on Immunization Practices of the CDC and the Health Resources and Services Administration. These services are recommended only for patients with certain risk factors (including age, high blood pressure, etc.). These recommended services will be covered at 100%, with no deductible, copayment, or other cost-sharing requirement. In addition to preventive services, some non-prescription medications are included in the recommendations. However, you will have to obtain a prescription for these otherwise non-prescription medications in order to receive the medication with no copayment.

   NOTE: Although the recommended preventive care services will be provided at no cost, you may be charged an office visit copayment or copayments for other services if non-preventive services are rendered at the same time.

4. **Internal Review and Appeal of Claims.** You will have additional rights regarding challenging or appealing any Adverse Benefit Determination. For example, if the Fund relies on newly received information in reviewing your claim for benefits, the Fund will provide you with a copy so that you can address any such additional information. If you would like to request a review or appeal of your claim, please call Lou Ann DeLong, Benefits Manager, at 610-320-9244, and you will be provided with all of the information you need to initiate the review or appeal. In the coming months, you will receive a Summary Plan Description that provides detailed information about these procedures and what you must do to seek an internal review and appeal of your claims.

5. **External Review of Claims.** In addition to appealing the denial of a claim for benefits through the Fund's internal review and appeal process, in certain cases, you will also have the right to request an external review by an independent review organization. The Fund will provide for this external review in compliance with all applicable federal guidance. If you would like to request an external review after you have exhausted the internal review and appeal procedures OR if your claim is an "urgent" claim and you would like to request concurrent internal and external reviews, please call Lou Ann DeLong, Benefits Manager, at 610-320-9244. In the coming months, you will receive a Summary Plan Description that provides detailed information about these procedures and what you must do to seek an external review of your claims.

B. COPAYMENT CHANGES

1. **$5 increase in Office Visit Copayment**.

    a. Network Provider: Effective January 1, 2012, you will have to pay a $20 co-payment per visit to a Network Non-specialist and $30 per visit to a Network Specialist. The Plan will pay benefits to cover the rest of the costs of the visit. The increase in copayments ($5) will also apply to rehabilitative, mental health and substance abuse therapy benefits.

    b. Non-Network Provider. For office visits to a non-Network Non-Specialist, the Plan will pay benefits equal to the lesser of UCR or billed charges, less a $30 co-payment that you will have to pay per visit. For office visits to a Non-Network Specialist, the Plan will pay benefits equal to the lesser of UCR or billed charges less a $55 co-payment that you will have to pay per visit. The increase in copayments ($5) will also apply to rehabilitative, mental health and substance abuse therapy benefits.

2. **Inpatient Hospitalization Copayment: $100.**

(a) Network Hospital. You will be required to make a $100 copayment for each hospital stay, after which the Fund will pay the Network charges in full.

(b) Non-Network Hospital. In addition to the required annual deductible ($200/$600) and coinsurance (10% up to $2,500/$5,000), you will be required to make a $100 copayment for each hospital stay in a non-Network hospital, after which the Plan will pay benefits in accordance with the Plan's Major Medical Provisions.

3. **Outpatient Surgery Copayment: $100**

(a) Network Provider. If you use a Network provider, the Plan will pay benefits in full after you pay a copayment of $100.

(b) Non-Network Provider. In addition to the required annual deductible ($200/$600) and coinsurance (10% up to $2,500/$5,000), you will be required to make a $100 copayment for outpatient surgery performed by a Non-Network provider.

4. **Emergency Room Copayment:**

Your copayment for an Emergency Room visit will be $100 (increased from $50), regardless of whether you visit a Network facility or Non-Network facility. If you are admitted, you will not be responsible for an additional $100 copayment as an Inpatient. After you have paid the $100 copayment, the Plan will pay benefits in full for medically necessary emergency room visits, regardless of whether you visit a Network or Non-Network Hospital.

5. **Ambulance / Life Flight Copayment:**

You will be required to make a $100 copayment for any ambulance or Life Flight transportation. If you are transported to a Non-Network facility and transported in a Non-Network ambulance, the Plan will pay benefits after you have paid the $100 copayment, and met your deductible and coinsurance requirements.

6. **Extended Networks**

If a Health America facility or provider is not readily accessible for you, you may need to access one of the providers available through the Fund's extended networks. Please note that the Beech St Network has been integrated into the PHCS/Multiplan networks. The PHCS network will replace the Beech Street network as the primary network for people living outside of DE, PA, NJ, VA, WV, MD, NC & DC. In addition, the PHCS network will be extended to all other participants of the Plan who are travelling out of the area and need to access a medical provider. New identification cards will be issued in the upcoming weeks.

7. **Opt Out- Option**

With respect to coverage offered to new groups coming into the Fund, or to existing groups who are either renewing collective bargaining agreements, or who have agreed to reopen the collective bargaining agreement with respect to health benefits coverage, the Fund will provide under Plan 14 an "Opt Out" option with the following provisions:

(1) The Participant may opt out and be covered under other (e.g. spouse's) coverage. (If this option is selected, the Participant's dependents may not be covered under the Plan); or

(2) The Participant and dependents may remain in the Plan while the Participant's spouse opts out of the Plan; or

(3) The Participant may remain in the Plan while the Participant' s spouse and dependents opt out of the Plan.

The Opt-Out option will be available to those groups that elect it and pay the applicable contribution. This option will allow a Participant to make an election (once annually, in a manner determined by the Fund) to exercise one of the options described above.

IMPORTANT: If a Participant, spouse or dependent has opted out of the Fund's coverage, but then loses the other health coverage, the affected individuals will have the opportunity to enroll in the Fund's coverage. In order to be eligible to enroll, the Participant or dependent must have had other health coverage when coverage under the Fund was previously declined. If the other coverage was COBRA continuation coverage, enrollment can be requested only after the COBRA continuation coverage is exhausted. If the other coverage was not COBRA continuation coverage, enrollment can be requested when the individual loses eligibility for the other coverage. In addition, a special enrollment

opportunity may be triggered when a person becomes a new dependent through marriage, birth, adoption or placement for adoption.

C. EFFECTIVE FOR PARTICIPANTS WHO RETIRE ON OR AFTER JUNE 1, 2012, FIFTEEN (15) YEARS OF COVERED EMPLOYMENT IS NOW REQUIRED TO BE ELIGIBLE FOR RETIREE BENEFITS FROM THE FUND.

In order to be eligible for a retiree plan under the Health & Welfare Fund, you must have been a Participant through your former employer or employers in Plan 13, 13Y, or 14 (with optional retiree coverage under Plan 14) for at least fifteen (15) years prior to your retirement. Previously, you needed to be a Participant through a former employer for ten (10) years to qualify for retiree coverage.

To satisfy the 15 year requirement, you must have two (2) years of continuous coverage immediately prior to your retirement and you must have had coverage for at least thirteen (13) of the prior eighteen (18) years. For purposes of meeting the thirteen (13) year requirement, participation for a twelve (12) month period will be considered participation for a year even if the months are not consecutive.