CENTRAL PENNSYLVANIA TEAMSTERS
HEALTH & WELFARE FUND
PLAN R-2

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 and (B) newly implemented copayments for certain services.

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. *Recall that under this plan, no office visit benefits are available.*

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 Rehabilitative Visit Copayment**.

   a. Network Provider: Effective January 1, 2012, you will have to pay a $20 co-payment per visit to a Network rehabilitative therapist.

   b. Non-Network Provider. For rehabilitative visits to a non-Network rehabilitative therapist, 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.

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. You will be required to make a $100 copayment for each hospital stay in a non-Network hospital. *Note that because the inpatient benefits in a Non-Network Hospital under this Plan are subject to dollar limits, it is possible that no benefits are payable under from the Plan.*

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. You will be required to make a $100 copayment for outpatient surgery performed by a Non-Network provider. *Recall that benefits for outpatient surgery by a Non-Network provider under this are limited to $500. Therefore, it is possible that no benefits will be payable.*

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. *Recall that there are benefits under this Plan only for Emergency Room visits for accidents; there are no benefits for Emergency Room visits for sickness.*

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.