Central Pennsylvania Teamsters
GUARDIAN
Health and Welfare Special Edition Newsletter
Reading, Pennsylvania
January 2012

Happy Holidays from the Central PA Teamsters Health and Welfare Fund!

Frequently Asked Questions

What co-pays are changing effective January 1, 2012?

- **$5 increase in Office Visit Copayment** (this includes rehabilitative, mental nervous and substance abuse visits if your plan provides those benefits)
- **Inpatient Hospitalization Copayment: $100**
- **Outpatient Surgery Copayment: $100**
- **Emergency Room Copayment Increased from $50 to $100**
- **Ambulance/Life Flight Copayment: $100**

If I go to the ER and am admitted to the hospital from the Emergency Room, will I owe an Emergency Room copay and an Inpatient Hospital copay?

No, you will only owe one copay under those circumstances.

Will the Plans have any Pre-Existing Exclusions after January 1, 2012?

No.

Can I enroll my adult children up to age 26, even if that child is offered coverage through their employer?

Yes.

Do these changes apply to Retiree Plans?

Yes.

BOARD OF TRUSTEES ANNOUNCES HEALTH & WELFARE BENEFIT CHANGES

The Board of Trustees of the Central Pennsylvania Teamsters Health & Welfare Fund announces benefit changes to the Health & Welfare Plans generally effective January 1, 2012. This newsletter includes information about:

A. Changes to the Plans have been 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.

Summaries of Material Modifications ("SMM's") describing these changes were mailed to Plan participants in late October. New Plan ID cards that include the changes will be mailed to participants shortly.

ACTIVE PLANS 13, 13Y, 14 AND 16

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.

You will find a list of the USPSTF "A" or "B" recommendations on the Fund's website (under Health and Welfare – Summary of Material Modifications.)

(Continued on page 2)

HEALTH AND WELFARE BENEFIT CHANGES

(Continued from page 1)

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.

   Please note that the mental health and substance abuse copay increases would only apply if your collective bargaining agreement includes that option as part of your coverage under Plans 14 and 16.

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 (Plans 13 and 13Y: $150/$450 deductible and 10% up to $2,000/$4,000 co-insurance and Plans 14 and 16: $200/$600 deductible and 10% up to $2,500/$5,000 co-insurance), 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 (Plans 13 and 13Y: $150/$450 deductible and 10% up to $2,000/$4,000 co-insurance and Plans 14 and 16: $200/$600 deductible 10% up to $2,500/$5,000 co-insurance), you will be required to make a $100 copayment for outpatient surgery performed by a Non-Network provider.

4. **Emergency Room Copayment: $100**
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5. **Ambulance / Life Flight Copayment: $100**
   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 Street 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.

C. EFFECTIVE FOR PARTICIPANTS IN PLANS 13, 13Y AND 14 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. DIFFERENT RULES APPLY TO PLAN 16.

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.

ADDITIONAL CHANGE TO PLAN 14:

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 offer under Plan 14 an "Opt Out" option to the bargaining parties 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 only 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.

RETIREE PLANS R-4, R-5, AND R-7/65

A. AFFORDABLE CARE ACT CHANGES:

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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.

You will find a list of the USPSTF "A" or "B" recommendations on the Fund's website (under Health and Welfare – Summary of Material Modifications.)

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

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   Please note that mental health and substance abuse copay increases would apply only if your plan includes that option as part of your coverage.

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.

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4. **Emergency Room Copayment: $100**

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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 Street 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.

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 your former employer or employers 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.

RETIREE PLAN R-7

A. AFFORDABLE CARE ACT CHANGES:

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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.

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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.

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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.

Have Health Care Questions? Call NurseLine.

NurseLine is a free service available 24 hours a day, 7 days a week to help you and your family with health issues. Call NurseLine toll-free, at **1-866-491-4462** for help when you are sick, injured or have a health care question.

Moonlighting/ Self-employment

The Health and Welfare Fund does not cover participants or their eligible dependents for illnesses or injuries that arise as a result of performing non-covered employment for wage or profit. Any time such service is rendered for wage or profit, there are no benefits (i.e. medical, short-term disability, etc.) payable by the Fund. Non-covered employment means any employment for which contributions are not made to the Fund. Unfortunately, in the past, there have been cases where an individual was performing odd jobs, i.e. painting, roofing, etc. for which they received payment. The individual was injured while performing the job and as a result, all bills and short-term disability benefits were denied. If you or your spouse intend to render services or be self-employed in any capacity for which a wage or profit is received, you must have the appropriate liability coverage to cover any injuries or illnesses which arise as a result of performing such services. ■

Motor Vehicle Accidents: How Are Medical and Wage Loss Benefits Paid by the Health and Welfare Fund?

The Fund Office receives many questions regarding coverage provided by the Fund when the claim is the result of an injury due to a motor vehicle accident. In accordance with Plan provisions, the Fund will **only** cover medical expenses on a subrogated basis once the maximum liability has been paid by the motor vehicle insurance carrier. *In other words, the Fund will consider the payment of medical expenses only after benefits from the automobile insurance carrier have been exhausted.*

The subrogation rules above also apply if you are injured while repairing your car or by any other contact with your car.

*In addition, the Fund will **not** provide coverage for short-term disability benefits (except for the first 5 days of missed work) for injuries sustained in a motor vehicle accident.* The only time the Fund will pay more than 5 days of short-term disability benefits is when written proof is submitted verifying that the state in which you reside does not allow you to purchase wage loss protection from your motor vehicle insurance carrier. The state of Pennsylvania allows residents to purchase wage loss protection. It is recommended that you contact your motor vehicle insurance carrier to evaluate the extent to which you are covered for wage loss benefits resulting from a motor vehicle accident. Check with your motor vehicle insurance carrier to ensure that your policy carries at least the minimum coverage required by the state in which you reside.

Do not wait until you have an accident to find out you have no wage loss coverage under your policy. Payment for the first 5 days of short-term disability benefits **does not** apply to motorcycle accidents. There are **no** short-term disability benefits payable for injuries sustained as a result of a motorcycle accident.

Prescription Plan Controlled Substance Change

General Prescription Programs (GPP) will now require that prescriptions for controlled substances will only be refilled when 90% of the prescription has been used.

Does the Health & Welfare Fund Offer a Wellness Program?

The Fund offers a Wellness Program that includes:

- a Health Risk Assessment,
- discounts on gyms and Weight Watchers and
- Wellness Reminders.
- Nurseline, a toll-free 24 hour hotline **(1-866-491-4462)** for participants to discuss their medical conditions with a registered nurse.

In addition, the Fund participates in a voluntary Disease Management Program, designed to help participants control diabetes and asthma. Participants who qualify for the program will receive educational materials, individualized support, and resources to help manage their condition.

For more information on the Central PA Teamsters Wellness Program, visit our website: **www.CentralPATeamsters.com**. It is located in the Health and Welfare Section under-Wellness.

Central Pennsylvania Teamsters Health and Welfare Fund Prescription Drug Benefits

Negative Formulary List*

Aciphex	Deprizine	Luvox	Prozac	Trilipix
Advicor	Dexilant	Mevacor	Relenza	Valturna
Altoprev	Diflucan	Nexium	Rozerem	Viibryd
Ambien**	Edluar	Oleptro	Sarafem	Vimovo
Axid	Effexor	Oravig	Silenor	Vioxx
Bextra	Fibricor	Paxil	Simcor	Vytorin
Cambia	Gilenya	Pepcid***	Sonata**	Xyzal
Celebrex	Lamisil	Pexeva	Sporanox	Zantac***
Celexa	Latuda	Pravachol	Symbyax	Zegerid
Clarinex	Lexapro	Prevacid	Tagamet	Zetia
Crestor	Lipitor	Prilosec****	Tamiflu	Zipsor
Cymbalta	Livalo	Pristiq	Tekamlo	Zocor
Daypro	Lunesta**	Protonix	Trepadone	Zoloft
				Zolpimist

And All Injectables (excluding Insulin and Imitrex)

Effective January 1, 2012, Incivek *and* Victrelis *will be added to the Negative Formulary List.*

*Please note that this listing is subject to change. Participants will receive notification (via newsletter, mailings, etc.) of additions and/or deletions.

**By law, controlled substances cannot be mail ordered. General Prescription Programs (GPP) will now require that prescriptions for controlled substances will only be refilled when 90% of the prescription has been used.

***Over the counter dosages are not covered.

****Effective 1/1/09, all new prescriptions for proton pump inhibitors (PPI's) will be subject to a Step Therapy Program. This means that the plan will cover only over-the-counter PPI's as a first step in treatment. If the OTC is ineffective, ask your doctor to write a letter (addressed to the Fund) stating the reason that you must have a prescription PPI.

Prescription Plan Benefits Under Plans 13, R4, R5 and R7

MAIL ORDER COPAYMENTS

$15 Generic for up to a 90 day supply
$30 Brand for up to a 90 day supply
$60 Negative Formulary up to a 90 day supply

RETAIL PHARMACY COPAYMENTS

$5 Generic for up to a 34 day supply
$15 Brand for up to a 34 day supply
$30 Negative Formulary up to a 34 day supply

Prescription Plan Benefits Under Plans 14, 16 and R6

MAIL ORDER COPAYMENTS

	Option A	Option B	Option C
Generic for up to a 90 day supply	$15.00	$30.00	$30.00
Brand for up to a 90 day supply	$30.00	$40.00	$60.00
Negative Formulary up to a 90 day supply	$60.00	$80.00	$100.00

Prescription Plan Benefits Under Plans 14, 16 and R6 (continued)

RETAIL PHARMACY COPAYMENTS

	Option A	Option B	Option C
Generic for up to a 34 day supply	$5.00	$10.00	$10.00
Brand for up to a 34 day supply	$15.00	$20.00	$30.00
Negative Formulary up to a 34 day supply	$30.00	$40.00	$50.00

Prescription Plan Benefits Under Plan 13Y

MAIL ORDER COPAYMENTS

$30 Generic for up to a 90 day supply
$60 Brand for up to a 90 day supply
$100 Negative Formulary up to a 90 day supply

RETAIL PHARMACY COPAYMENTS

$10 Generic for up to a 34 day supply
$30 Brand for up to a 34 day supply
$50 Negative Formulary up to a 34 day supply

Central PA Teamsters
P.O. Box 15223
Reading, PA 19612-5223

Return Service Requested

Non-Profit Org.
U.S. POSTAGE
PAID
Reading, PA
Permit No. 144

Visit Our Website

Members and their families, as well as contributing employers, can access the Fund website, www.CentralPATeamsters.com for benefits information, announcements, reports and notices, investment reports, forms, wellness information and provider network links.

Participants in the Retirement Income Plan (RIP) 1987 can view their account balances (updated monthly) by visiting the **Pension Web Portal** page. You must register first before you can access your account information.

Smart phone users can access the website by using the scanning feature on their phones. Users must first download a bar code or QR reader app to their smart phone. Simply scan the code and you will be directed to the website.

Important Information from the Fund Office

Fund Office Contact Information

Contact the Fund Office directly with any questions on Health and Welfare benefits. The Fund staff is available Monday through Friday from 7:30 a.m. to 4:00 p.m.

Health & Welfare Office
(610) 320-5500
Toll free in PA: 1-800-422-8330
Nationwide: 1-800-331-0420

Reminder –
Keep Your Information Current with the Fund Office

Please remember to keep your address, dependent and beneficiary information updated with the Fund. You can call or mail in address changes to the Fund. You can call the Fund office or visit www.CentralPATeamsters.com to obtain beneficiary change forms to complete and send in to the Fund Office.

Note: The Fund Office has extended its hours on a trial basis from 7:30 a.m. to 5:00 p.m.

Visit Our Website at:
www.CentralPATeamsters.com

Central Pennsylvania Teamsters Health and Welfare Fund

Trustees:

William M. Shappell
Chairman & Union Trustee

Tom J. Ventura
Secretary & Employer Trustee

Tomm Forrest
Employer Trustee

J. Christopher Michael
Employer Trustee

Keith L. Noll
Union Trustee

Howard W. Rhinier
Union Trustee

Kenneth A. Ross
Employer Trustee

Daniel W. Schmidt
Employer Trustee

Charles Shafer
Union Trustee

Keith A. Youst
Union Trustee

Joseph J. Samolewicz
Administrator

Martin L. Cullen
Assistant Administrator

Professional Advisors:

Beyer-Barber
Health & Welfare Fund Actuary & Consultant

Morgan Lewis
Legal Co-Counsel

Novak Francella, LLC
Certified Public Accountants

Summit Strategies
Investment Consultant

Stevens & Lee
Legal Co-Counsel

Willig, Williams and Davidson
Legal Co-Counsel

Investment Managers for the Central Pennsylvania Teamsters Health and Welfare Fund:

Aronson+Johnson+Ortiz, LP
Causeway Capital Management, LLC
INTECH Investment Management, LLC
Rothschild Asset Mgt., Inc.
SEI Investments
Tortoise Capital Advisors LLC
Walter Scott & Partners, Ltd.