# Central Pennsylvania Teamsters Health and Welfare Fund

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**CENTRAL PENNSYLVANIA TEAMSTERS**
**HEALTH & WELFARE FUND**
**PLAN 13, 13Y, 14, 16, R7/R7-65**
**Summary of Material Modification**
**June - September 2019**
**Important changes to your benefits! Please read carefully.**

1. **Prescription Benefits: Pharmacy Benefit Manager Discretion**: The Trustees have implemented a number of prescription benefit plan features designed to ensure that Participants and their family members receive the medications they need while also protecting the Fund's financial soundness and its ability to continue to provide comprehensive benefits. Two of these are (1) the use of a Formulary, that is, a list of brand-name and generic prescription drugs selected for their efficacy, safety and cost and that are covered by the Fund at the lowest copayment for the Participant; and (2) implementation of a step therapy program. Step Therapy is a process under which a patient who is beginning a drug therapy starts with the most cost-effective and safest medication (Step I) and progresses to other more costly or risky therapy (Step II), and then only if "medically necessary."

   The amendment recently adopted by the Trustees grants to the Fund's pharmacy benefit manager ("PBM"), based on the PBM's professional pharmaceutical knowledge and experience, the discretion to add or delete medications from the Fund's Formulary and Step Therapy List and to determine which classifications of prescription medications are subject to step therapy and to determine the appropriate step for such prescription medications.

2. **Definition of "Other Insurance"**: The Fund's Coordination of Benefits rules describe the order in which benefits are paid when an individual has coverage from more than one source. For example, if a Spouse has coverage under her own employer's plan, that is, "Other Coverage," that plan pays first, or primary, and the Fund's coverage pays after all benefits are paid under the "Other Coverage," or secondary. The Trustees recently adopted an amendment to clarify that "Other Coverage" includes not only group health benefits coverage but also any "account-based arrangement" like a "health reimbursement arrangement" or similar account, regardless of how it is characterized. (Note that this does **not** include a "health savings account" as that term is defined in IRC Section 223.) Section (a) of the definition of "Other Insurance" now reads as follows:

(a) Any group health benefits coverage, including any plan covering individuals as employees of an employer or as members of any other group that provides hospital or medical care benefits or services on an insured, self-insured or account-based arrangement, including health reimbursement arrangements or similar accounts, however denominated.

3. **Exception to the Spousal Waiver Rule: (Active Plans Only)** The Trustees have adopted a narrow exception to the Fund's Spousal Waiver Rule when your Medicare-eligible Spouse works for an employer with fewer than 20 employees. This exception applies only if all of the following criteria are met. Your Spouse must be:

    - Actively employed;

    - The Spouse's employment is with an employer that is not an Employer required to make Contributions to the Fund; that has fewer than 20 employees; and whose health coverage, pursuant to the Medicare Secondary Payer Rules, would not be primary for the Spouse; *and*

    - The Spouse has elected Medicare Parts A and B.