The Philadelphia Update

Teamsters Health & Welfare Fund of Philadelphia & Vicinity

Open Enrollment for the Health & Welfare Fund Begins January 1 and Ends February 5, 2016!

It's Your Chance to Choose Between the HMO & PPO Coverage Options for the Benefit Period Beginning March 1, 2016

Open Enrollment is your annual opportunity to review your medical plan choices. All changes will be effective March 1, 2016. Take some time to review this Newsletter. Given the benefit changes that will occur on March 1, 2016 it is more important than ever that you familiarize yourself with your benefit options.

We have included a Summary of Benefits & Coverage (SBC) for each medical program — one for the PPO and one for the HMO — as well as a Statement of Material Modification explaining the benefit changes to the Health & Welfare Fund. Also visit www.teamsterfunds.com for Open Enrollment information and links to each medical program's online provider directory.

If you are presently enrolled in the BlueCard PPO program and don't want to make any change to your present coverage, you don't have to do a thing. If you have PPO coverage now and don't do anything, as of March 1, 2016 you'll still enjoy coverage under the PPO program. If you have BlueCard PPO coverage and want to switch to the Aetna HMO coverage effective March 1, 2016, call 1-800-523-2846 to have an enrollment kit mailed to you. You must fill out the enrollment form, choose a Primary Care Physician, AND have the enrollment form returned to the Fund office before the open enrollment period ends on February 5, 2016.

If you have Aetna HMO coverage now and want to keep that HMO coverage as of March 1, 2016, you don't have to do a thing. If you have HMO coverage now and don't do anything, as of March 1, 2016 you'll still enjoy coverage under the HMO program. If you have Aetna HMO coverage and want to switch to the Blue Cross PPO coverage effective March 1, 2016, call the Fund office at 1-800-523-2846 for a coverage change form (a copy is also available on the Fund's web site).

If you wish to change your coverage for the coming year, YOU MUST ACT NOW!!! FEBRUARY 5, 2016 IS THE ABSOLUTE DEADLINE FOR RECEIPT OF YOUR CHANGE REQUEST!!!

Fund Administrator Retires; Trustees Appoint Successor

The Health & Welfare and Pension Funds' long-time Administrator, William J. Einhorn, retired effective September 1, 2015 after over 30 years of service to the Funds as their attorney, Assistant Administrator, and Administrator. The Funds' Trustees have appointed Adam H. Garner, the Funds' former Assistant Administrator, to serve as only the third Administrator in the Funds' 64-year history.

Bill Einhorn joined the Funds as their Assistant Administrator in 1989 after serving as their attorney beginning in 1979. He was promoted to Administrator in 1995 upon the retirement the Funds' first Administrator, Charles Schaffer, Jr. During his tenure, Mr. Einhorn guided the Funds through tremendous regulatory and demographic changes. Mr. Einhorn worked tirelessly to ensure the long-term viability of the Funds and to protect the benefits of their participants.

Adam Garner joined the Funds as their Assistant Administrator in late April 2012. Prior to assuming that role, he was a labor and employment lawyer with a large law firm for many years where he spent a significant amount of time handling employee benefits matters. He is a graduate of the University of Miami School of Law and the Goizueta Business School of Emory University.

Health & Welfare Member Services

Telephone: 1-800-523-2846 or 856-382-2400
Hours: Mon-Tues, Thurs.-Fri. 8:00 a.m. to 4:30 p.m.
Wed. 8:00 a.m. to 8:00 p.m.

Changes Made to the Health & Welfare Fund to Reflect Increased Costs & ACA-Mandated Changes

A letter was recently mailed to Health & Welfare Fund participants explaining why the Board of Trustees of the Teamsters Health and Welfare Fund of Philadelphia and Vicinity made several changes to the Fund's Plan of Benefits. The changes are effective as of March 1, 2016 and are explained in greater detail in the enclosed Open Enrollment materials. The changes are necessary to ensure the long-term financial stability and value of your health and welfare benefits.

The Fund's Plan of Benefits has remained essentially unchanged in the last 10 years. During that time, per employee medical costs rose 33.5%, per employee prescription drug costs rose 84%, but participant cost sharing rose 0%. In addition, the passage of the Patient Protection and Affordable Care Act ("the ACA"), which is also sometimes referred to as "Obamacare," also significantly increased the Fund's costs. The Fund successfully absorbed many of these increased costs for the last 10 years through increases in the Contributing Employer contribution rate and strong investment returns.

The Fund operated at more than a $7 Million deficit through the end of September 2015 because of increased medical claims and high cost prescription drugs. In 2014, high cost claimants and costly prescription drugs resulted in the Fund losing over $1.5 Million. The Trustees believe that the economic realities facing the Health & Welfare Fund require making some common sense changes to the Fund's Plan of Benefits. These changes are projected to protect the stability of the Fund, while at the same time continuing to provide the Fund's participants with the same high quality benefits they have come to expect.

The Fund is making changes to its overall benefit design and member cost-sharing provisions, which are explained in more detail in this newsletter and the enclosed Open Enrollment materials. Generally speaking, the Fund's cost sharing provisions are increasing slightly. That having been said, Fund participants can expect to receive a greater range of benefits than they currently enjoy under the Plan that is in effect today because the Fund will cease to be a "Grandfathered Plan." By giving up its grandfathered status, all of the ACA's provisions and protections for individuals will apply to the Fund.

In addition to changes to the Fund's cost-sharing provisions and the abandonment of the Fund's grandfathered status, the Fund will implement a voluntary wellness screening program, which will decrease the healthcare costs of Fund participants who choose to participate beginning in the 2017 plan year. The wellness screening program is open to participants and their spouses, if they are are married and do not have single-only coverage. Additional information about the wellness screening program is included in the enclosed Open Enrollment materials and will also be mailed out to Fund participants in early 2016.

Annual Notice Regarding Post-Mastectomy Reconstructive Surgery Benefits

As required by the Women's Health and Cancer Rights Act of 1998, the Health & Welfare Fund's Plan provides (as it always has) benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedemas). For more information, contact the Fund's Member Services Department at 1-800-523-2846.

What's Staying the Same for Plan Year 2016 and What is Changing?

*No change in the Fund's life insurance and accidental death and dismemberment benefit in 2016.

*Total Care Network continues to administer the mental health and substance abuse benefit (regardless of whether you choose the PPO or HMO medical program)

*Dental and vision coverages will remain the same for both PPO and HMO participants

*PPO participants can avoid out-of-pocket costs by using LabCorp or Quest for their outpatient laboratory needs and the Health Care Solutions network for their diabetic supplies and out-patient radiology services needs.

*You can continue to save time and money, without sacrificing care, by visiting Urgent Care Centers, rather than hospital emergency rooms for non-life threatening care.

*Copayments, deductibles and coinsurance are changing for the PPO, HMO and prescription drug programs.

*Behavioral health and substance abuse benefits have been enhanced by removing annual and lifetime limits.

General Comparison of the PPO and HMO Plan Options Effective March 2016

	Horizon PPO		Aetna HMO
	In-Network	Out-of-Network	In-Network Only
Annual Deductible	$250/Person $500/Family	$500/person $1,000/Family	$100/Person $200/Family
Coinsurance Maximum	$500/Person	$1,500/Person	$250/Person
Annual Medical Out-of-Pocket Maximum* (Includes Copayments, Coinsurance, & Deductibles, but excludes balance billed charges by out of network providers)	$5,000/Person $10,000/Family		$5,000/Person $10,000/Family
SERVICES WITH COPAYMENTS			
Primary Care Copayment	$20	80%, after deductible (Members may be balance billed)	$15
Specialist	$30	80%, after deductible (Members may be balance billed)	$25
Emergency Room	$100 (Waived if admitted)	80%, after deductible (Members may be balance billed)	$100 (Waived if admitted)
Urgent Care Centers	$50	80%, after deductible (Members may be balance billed)	$50
Physical, Speech, & Occupational Therapy	$30	80%, after deductible (Members may be balance billed)	$0 (up to 60 consecutive days per condition covered, subject to significant improvement)
SERVICES TO WHICH COINSURANCE APPLIES			
Inpatient Hospital Stays	90%, after deductible	80%, after deductible (Members may be balance billed)	90%, after deductible
Outpatient Hospital Stays	90%, after deductible	80%, after deductible (Members may be balance billed)	90%, after deductible
Skilled Nursing Facilities	90%, after deductible	80%, after deductible (Members may be balance billed)	90%, after deductible
Durable Medical Equipment & Prosthetics	90%, after deductible **	80%, after deductible (Members may be balance billed)	90%, after deductible (when authorized by Primary Care Physician and approved by Aetna)
PRESCRIPTION DRUG BENEFITS* **			
Generic Drugs (30-Day Supply)	$5		
Preferred Brand Drugs (30-Day Supply)	$15		
Non-Preferred Brand Drugs (30-Day Supply)	Minimum of $30 and a Maximum of $50		
Specialty Drugs (30-Day Supply)	$100		
Prescription Drug Co-Payment Maximum (no charge for medication after maximum is reached)	$1,500/Person $3,000/Family		

*In 2015, there was no out-of-pocket maximum for medical benefits in the PPO program. This change benefits participants. The medical benefit out-of-pocket maximum and the prescription drug out-of-pocket maximums are separate.

**Plan pays 100% of the allowable charges after the $500 yearly out-of-pocket coinsurance maximum for that patient is reached. Lower or no copays available when using the Healthcare Solutions provider network for outpatient lab (LabCorp or Quest) and x-ray services.

***A 90-day supply of certain maintenance drugs for a single copayment will remain available by mail order. The copayment charged will be the copayment applicable to that particular medication (e.g., $5 for a generic or $100 for a specialty medication).

DO NOT DISCARD!

TEAMSTERS HEALTH & WELFARE FUND

NEWSLETTER &

OPEN ENROLLMENT

MATERIALS ENCLOSED

We respect your privacy!

Learn more about the Fund's privacy policy by reading your Summary Plan Description or visiting the Fund's web site. The Privacy Policy is posted at:

https://www.teamsterfunds.com/members/health-welfare-benefits/privacy-policy/

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