*Special pull-out section; please keep for future reference and use*

# TEAMSTERS HEALTH & WELFARE FUND

*of Philadelphia and Vicinity*

## STATEMENT OF MATERIAL MODIFICATION

**This document sets forth, in a summary fashion, changes to your benefit plan that will generally take effect on March 1, 2016.**

**We urge you to review this material carefully and keep it with your other plan documents and newsletters for future reference.**

*December 2015*

# INTRODUCTION

The Trustees have made several changes to the Plan of Benefits of Teamsters Health and Welfare Fund of Philadelphia and Vicinity. Unless otherwise stated, the changes set forth in this Statement of Material Modification are effective as of 12:00 a.m. on March 1, 2016. To the extent that any of the provisions in this Statement of Material Modification conflict with the terms of the Summary Plan Description of the Plan of Benefits of the Teamsters Health and Welfare Fund of Philadelphia and Vicinity (March 2013) (the "Summary Plan Description"), the provisions set forth in this document amend and supersede any conflicting prior provisions. Otherwise, all other provisions of the existing Summary Plan Description remain in full force and effect.

**Notice of Grandfathered Status from January 1, 2016 to February 29, 2016**

The Fund believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the ACA). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the ACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the ACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Administrator at 6981 N. Park Drive, Suite 400, Pennsauken, NJ 08109 or at 856-382-2400. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

**As discussed in more detail below, the Fund will cease to be a grandfathered plan on March 1, 2016.**

# PLAN DESIGN CHANGES

## I. General Changes

### A. Dependent Spouses

Prior to March 2016, the Fund did not cover Separated Spouses as eligible dependents. That meant that your spouse ceased to be a "Spouse," as that term is defined under the Plan, once you separated. Effective, March 1, 2016 the term Spouse shall include a Separated Spouse. This means your Spouse will remain an eligible dependent under the terms of the Fund's Plan of Benefits until the earlier of your date of divorce, the date of annulment of your marriage, or your Spouse's death.

### B. Claims Review Procedure

Prior to March 1, 2016, Fund participants have two levels of appeal they must pursue if they wish to contest an adverse benefit determination before they may file a lawsuit in court against the Fund. Those appeals are before the Fund's Claims Review Committee and the Appeals Committee of the Fund's Board of Trustees. Effective March 1, 2016, a Fund participant may also seek an independent external review of certain adverse benefit determinations after exhausting his or her internal appeals, but before filing a lawsuit in court. Unlike the two internal levels of appeal, the external independent review process is voluntary.

The following types of adverse benefit determinations are subject to independent external review:

1. an adverse benefit determination that involves medical judgment; and
2. a rescission of coverage under the Fund's Plan of Benefits.

A participant seeking an independent external review under this process must file a request for an external review with the Fund within four months after the date of receipt of a notice of a final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice.

Within five business days following the date of receipt of the external review request, the Fund will complete a preliminary review of the request to determine whether the request is eligible for external review. Within one business day after completion of the preliminary review, the Fund will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and current contact information, including the phone number, for the Employee Benefits Security Administration, a division of the U.S. Department of Labor. If the request is not complete, the notification will describe the information or materials needed to make the request complete, and the Fund will allow the Participant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

If the appeal is eligible for external review and the request is properly filed in a timely fashion, the Participant's appeal will be forwarded to a properly accredited Independent Review Organization ("IRO"). The Fund will ensure that the IRO process is not biased and is truly independent. The external review will be conducted at no cost to the participant requesting review. The assigned IRO will utilize experts where appropriate to make coverage determinations under the plan or coverage. The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim anew and not be bound by any decisions or conclusions reached during the Fund's internal claims and appeals process. The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of the final external review decision to the Participant and to the Fund.

## II. Changes to the Fund's Behavioral Health Program

Effective *January 1, 2016*, the Fund's Plan has been amended to incorporate the requirements of the Mental Health Parity and Addiction Equity Act of 2008. This means that the financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits and yearly hospital day limits) applicable to mental health or substance use disorder benefits are no more restrictive than the requirements or limitations applied to substantially all medical/surgical benefits. More specifically:

A. all annual and lifetime quantity limits on behavioral health and substance abuse benefits are removed;

B. all outpatient behavioral health and substance abuse treatment will be subject to a $15 copayment ($20 effective March 1, 2016) for in-network providers and 80% coinsurance for out-of-network providers (out-of-network outpatient treatment will otherwise be treated in accordance with the Fund's current procedures related to the payment of out-of-network medical benefits);

C. all inpatient behavioral health and substance abuse treatment will be subject to the same limitations, deductibles and coinsurance, and/or copayment provisions as the medical Plan's other forms of inpatient medical/surgical treatment.

The terms "in-network" and "out-of-network" will, with respect to behavioral health and substance abuse treatment, have the same meanings as those set forth in the March 2013 version of the Plan document.

The Fund will continue its relationship with Total Care Network ("TCN") with respect to behavioral health and substance abuse benefits. All Fund Participants are required to continue to coordinate their behavioral health and substance abuse benefits through TCN. TCN representatives may be reached at 1-800-298-2299.

## III. Changes to the Fund's Medical Plan

### A. Abandonment of Grandfathered Status

The Fund has remained a "Grandfathered Plan" since the enactment of the Patient Protection and Affordable Care Act ("ACA"), which is also sometimes called "Obamacare." This means that some, but not all, of the ACA's provisions have been applied to the Plan. For example, the Fund does not apply any annual or lifetime limits on the amount of health benefits you may receive, and it covers dependent children up to age 26, but does not currently cover contraceptives for contraceptive purposes.

On March 1, 2016, the Fund will cease to be a Grandfathered Plan and will come into full compliance with all applicable provisions of the ACA. Notwithstanding any legacy provision in the March 2013 plan document to the contrary, the Fund's Plan of Benefits will be administered by the Fund's Administrator and Trustees in full compliance with the terms of the ACA. All of the Fund's participants and their beneficiaries will benefit from this change by having access to a greater range of benefits, and by eliminating certain cost sharing provisions of the Fund's Plan of Benefits. The benefits enhancements include, but are not limited to, the following:

1. **Certain in-network preventative services without any cost sharing for all adults, including:**

    a. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
    b. Alcohol Misuse screening and counseling (under the Fund's behavioral health program)
    c. Aspirin use for men and women of certain ages
    d. Blood Pressure screening for all adults
    e. Cholesterol screening for adults of certain ages or at higher risk
    f. Colorectal Cancer screening for adults over 50
    g. Depression screening for adults (under the Fund's behavioral health program)
    h. Type 2 Diabetes screening for adults with high blood pressure
    i. Diet counseling for adults at higher risk for chronic disease
    j. HIV screening for all adults at higher risk
    k. Immunization vaccines for adults – doses, recommended ages, and recommended populations vary (but will follow NIH guidelines):

i. Hepatitis A
ii. Hepatitis B
iii. Herpes Zoster
iv. Human Papillomavirus
v. Influenza (Flu Shot)
vi. Measles, Mumps, Rubella
vii. Meningococcal
viii. Pneumococcal
ix. Tetanus, Diphtheria, Pertussis
x. Varicella

l. Obesity screening and counseling for all adults
m. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
n. Tobacco Use screening for all adults and cessation interventions for tobacco users
o. Syphilis screening for all adults at higher risk

**2. Certain in-network preventative services without any cost sharing for women, including:**

a. Anemia screening on a routine basis for pregnant women
b. Bacteriuria urinary tract or other infection screening for pregnant women
c. BRCA counseling about genetic testing for women at higher risk
d. Breast Cancer Mammography screenings every 1 to 2 years for women over 40
e. Breast Cancer Chemoprevention counseling for women at higher risk
f. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
g. Cervical Cancer screening for sexually active women
h. Chlamydia Infection screening for younger women and other women at higher risk
i. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
j. Domestic and interpersonal violence screening and counseling for all women
k. Folic Acid supplements for women who may become pregnant
l. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
m. Gonorrhea screening for all women at higher risk
n. Hepatitis B screening for pregnant women at their first prenatal visit
o. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women
p. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
q. Osteoporosis screening for women over age 60 depending on risk factors

r. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
s. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
t. Sexually Transmitted Infections (STI) counseling for sexually active women
u. Syphilis screening for all pregnant women or other women at increased risk
v. Well-woman visits to obtain recommended preventive services

**3. Certain in-network preventative services without any cost sharing for children, including:**

a. Alcohol and Drug Use assessments for adolescents
b. Autism screening for children at 18 and 24 months
c. Behavioral assessments for children of all ages (under the Fund's behavioral health program)
   Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
d. Blood Pressure screening for children
   Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
e. Cervical Dysplasia screening for sexually active females
f. Congenital Hypothyroidism screening for newborns
g. Depression screening for adolescents (under the Fund's behavioral health program)
h. Developmental screening for children under age 3, and surveillance throughout childhood
i. Dyslipidemia screening for children at higher risk of lipid disorders
   Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
j. Fluoride Chemoprevention supplements for children without fluoride in their water source (under the Fund's dental program)
k. Gonorrhea preventive medication for the eyes of all newborns
l. Hearing screening for all newborns
m. Height, Weight and Body Mass Index measurements for children
   Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
n. Hematocrit or Hemoglobin screening for children
o. Hemoglobinopathies or sickle cell screening for newborns
p. HIV screening for adolescents at higher risk
q. Immunization vaccines for children from birth to age 18 - doses, recommended ages, and recommended populations vary (but will follow NIH guidelines):

   i. Diphtheria, Tetanus, Pertussis
   ii. Haemophilus influenzae type b
   iii. Hepatitis A
   iv. Hepatitis B
   v. Human Papillomavirus
   vi. Inactivated Poliovirus

vii. Influenza (Flu Shot)
viii. Measles, Mumps, Rubella
ix. Meningococcal
x. Pneumococcal
xi. Rotavirus
xii. Varicella

r. Iron supplements for children ages 6 to 12 months at risk for anemia
s. Lead screening for children at risk of exposure
t. Medical History for all children throughout development
Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
u. Obesity screening and counseling
v. Oral Health risk assessment for young children (under the Fund's dental program)
Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
w. Phenylketonuria (PKU) screening for this genetic disorder in newborns
x. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
y. Tuberculin testing for children at higher risk of tuberculosis
Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
z. Vision screening for all children (under the Fund's vision program)

## B. Changes to Patient Cost Sharing Provisions

Effective March 1, 2016, there will be several increases in the Fund's cost sharing provisions. In most cases, these increases are relatively small. The increases apply to the Fund's PPO and HMO programs. Regardless of which program a Participant is enrolled in, none of the Fund's deductible, co-insurance, or copayment provisions will apply to those services for which the ACA mandates no cost sharing by plan Participants.

### 1. HMO Program Patient Deductibles and Co-insurance

Effective March 1, 2016, the Fund's HMO program will include a participant deductible of $100 per person and $200 per family and co-insurance of 10% on the next $2,500 of allowable charges, with a out-of-pocket co-insurance maximum of $250 per person per year.

### 2. PPO Program Patient Deductibles and Co-insurance

The in-network deductible set forth the in the Plan's PPO program will be increased from $225 per person per year and $450 per family per year to $250 and $500, respectively. The coinsurance out-of-pocket maximums set forth in the Plan will remain the same. All outpatient lab work will be subject to the Fund's deductible and coinsurance provisions, unless such lab work is obtained through a Healthcare Solutions Corporation participating laboratory company (e.g., Quest Diagnostics and LabCorp), in which case no cost sharing will be applied.

## C. Patient Copayments

1. HMO Program

Effective March 1, 2016, patient copayments for primary and specialist office visits shall be $15 and $25, respectively. There will be no limit on HMO co-payments, other than those waived by virtue of reaching the overall out-of-pocket maximum (discussed below) in a given plan year.

2. PPO Program

Effective March 1, 2016, patient copayments for in-network primary and specialist office visits will be be $20 and $30, respectively. The patient copayment for outpatient therapy visits (other than for outpatient mental health/substance abuse visits) will be $30.

## D. Overall Out-of-Pocket Maximum

Regardless of whether an individual participates in the PPO or HMO program, his or her overall out-of-pocket medical expenses for in-network benefits will be capped at $5,000 per person per year and $10,000 per family per year.[1] This figure includes any applicable medical deductibles, coinsurance, and copayments. Thus, once an individual reaches this limit, he or she will not have to pay any additional amounts for in-network medical or behavioral health/substance abuse benefits in a given plan year.

## E. Wellness Program Requirements

Effective March 1, 2016, all Fund participants and their eligible dependent spouses will be offered an opportunity to participate in a wellness screening between March and September 2016, and during the same period for each Plan year thereafter. The wellness screening will be conducted by a vendor selected by the Trustees (currently Quest Diagnostics) and will measure the individual's blood pressure, weight, height, waist size, glucose (blood sugar) and cholesterol. The results of the wellness screening will be shared with the individual who was screened as well as with the Fund's disease management vendor for analysis.

Those individuals or married couples who choose not to participate in the Fund's wellness screening program described in the paragraph immediately above will participate in a new, alternative medical and prescription drug benefit program during the plan year commencing on **January 1, 2017**, or each Plan year thereafter in those cases in which the individuals or married couple choose not to participate in the wellness program in the prior plan year. The alternative medical and prescription drug benefit program will be known as Teamsters Health and Welfare Fund Gold Plan ("the Gold Plan"). Those who participate in the wellness program will remain in the Fund's preferred, primary medical and prescription drug benefit program, which will be renamed the Teamsters Health and Welfare Fund Platinum Plan ("the Platinum Plan"). The Gold Plan will generally provide the same benefits as the Platinum Plan subject to the following exceptions:

1. Gold Plan participants and their eligible dependent beneficiaries shall be subject to an annual medical in-network deductible of $500 per person per year and $1,000 per family per year for in-network care;

[1] These amounts are in addition to and do not include the out-of-pocket maximums for prescription drug benefits.

2. Gold Plan participants and their eligible dependent beneficiaries shall be subject to an annual medical out-of-network deductible of $1,000 per person per year and $2,000 per family per year for out-of-network care;

3. Gold Plan participants and their eligible dependent beneficiaries shall be subject to an in-network out-of-pocket medical coinsurance maximum of $750 per year for in-network care;

4. Gold Plan participants and their eligible dependent beneficiaries shall be subject to an out-of-network out-of-pocket medical coinsurance maximum of $2,250 per year for out-of-network care;

5. Gold Plan participants and their eligible dependent beneficiaries shall be subject to office copayments of $30 for any benefit that would require a $20 copayment under the Platinum Plan and $40 for any benefit that would require a $30 copayment under the Platinum Plan; and

6. Prescription drug copayments will be $10 for a 30-day supply of generic medications, $20 for a 30-day supply of preferred, non-specialty medications, $60 for a 30-day supply of non-preferred, non-specialty medications, and $150 for a 30-day supply of specialty medications.

A participant and his or her dependent beneficiaries enrolled in the Gold Plan will remain in the Gold Plan for a minimum of one full calendar quarter. A participant and his or her spouse who become compliant with the Fund's wellness screening requirement will be enrolled in the Platinum Plan during the calendar quarter following the quarter in which such individual or married couple becomes compliant with the wellness screening process.

Commencing with the 2017 Plan year, all participants will be required, in addition to the wellness screening requirements set forth above, to obtain at least one (1) preventive dental examination/check-up per Plan year in order to remain in the Platinum Plan in the following plan year.

## IV. Changes to the Plan's Prescription Drug Program Effective March 1, 2016

### A. Patient Copayments and Yearly Copayment Maximums

1. Copayments for generic drugs shall increase from $3 to $5 for a 30-day supply;

2. Copayments for preferred, non-specialty drugs shall increase from $10 to $15 for a 30-day supply;

3. Copayments for non-preferred, non-specialty medications shall increase from a minimum of $30 to a maximum of $40 for a 30-day supply to a minimum of $30 and a maximum of $50 for a 30-day supply;

4. All prescription medications shall be subject to an annual copayment limit of $1,500 per person and $3,000 per family, upon the satisfaction of which no additional

prescription drug cost-sharing shall be imposed for the remainder of the Plan year;

**B. New 4th Tier for Specialty Drugs**

All specialty medications shall be subject to a $100 copayment for a 30-day supply. A specialty medication is a high-cost prescription drug that treats complex conditions and requires special handling and administration. Specialty medications will be identified by and designated as such by the Fund's Pharmacy Benefits Manager ("PBM").

**C. Quantity Limits**

The Fund's plan will not generally provide benefits for any prescription drug for which the prescribing medical provider has prescribed a dosage that exceeds the dosage guidelines of the drug's manufacturer or the FDA, unless specific programs or recommendations are provided to the Fund by the Fund's PBM.

**D. New-to-Market Drugs**

All new-to-market medications approved for use by the federal Food and Drug Administration ("FDA") shall be automatically and completely excluded from coverage under the Fund's Plan for the first six (6) months following their launch date on the public market or such shorter period of time as recommended by the Fund's PBM.

***Questions concerning these changes may be directed to the Fund's Member Services Department. Our representatives may be reached at 1-800-523-2846 or can be emailed at claims@teamsterfunds.com.***