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Update

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Ever Increasing Health Care Costs Force Trustees to Implement Changes in Health & Welfare Coverage

Last year, the Pension Fund Trustees had to address potentially serious funding issues by adjusting benefits to ensure the continued financial stability of the Pension Fund. Unfortunately, the situation has proven to be just as difficult on the Health and Welfare side of the table.

It should come as no surprise to anyone that this country is in the midst of a health care cost crisis. Newspaper article after newspaper article informs us that the cost of medical care is escalating at the fastest rate in more than a decade. The cost of providing medical care has risen on a national basis by over 50% between the beginning 2001 through the end of last year.

The situation has been even worse with respect to the Fund's health care bill. ***It has nearly doubled in just four years!*** Despite having made changes to medical and prescription drug copayments in January 2003 and making slight adjustments to the prescription drug program in July of 2004, benefit expenditures have continued to out strip contributions to the point where Fund reserves have been significantly depleted and are now dangerously low.

The cost of providing benefits increased from $55.4 Million for Plan Year 2000 to $99.4 Million in 2004, just four years later. On a per member, per month basis, contribution income equaled $549.21 in calendar year 2000 with benefits costing $542.64. But by Plan Year 2004, contribution income stood at $728.95 per member, per month, with benefits costing $808.70. The bottom line is that contribution income has not been sufficient to cover Plan costs at current benefit levels.

At the same time, the Fund has done its best to hold the line on contribution rate increases. The Trustees are very much aware that collective bargaining has not been easy these past few years. Members surely did not want all of their hard earned hourly increases to go toward health care coverage. Even so, ***despite a 52% increase in the daily average contribution rate from 2000 to 2004, the contribution rate increases have not been sufficient to cover Plan costs.***

In years past, investment income earned on Fund reserves helped, in the largest part, to make up any shortfall between contribution income and benefit expenses. Unfortunately, the financial markets from 2000 through 2002 were less than kind. Instead of making money on the investment of Fund reserves, the Fund lost $100,000 in 2000, lost $1.2 Million in 2001 and lost $2.5 Million in 2002. This also happened during the years when the Fund needed investment income the most. The result was a more rapid depletion of Fund reserves. As of December 31, 2000, net assets of the Fund stood at $69.7 Million. By the end of 2004, those net assets stood at $32.5 Million, a decrease of 54%. Expressed in terms of months in reserve, at the end of 2000, the Fund has 15 months of Plan costs in reserve. By the end of 2004, that amount had dropped to under four months in reserve.

The Trustees, as other trustees in other funds have done, had to face this issue head on and bring costs to an affordable level to prevent the Fund from going bankrupt. The Trustees have been involved in long and intense meetings with Plan professionals, particularly with the Fund's Actuary, to identify problems and formulate solutions. ***The Fund's Actuary has projected that without making any changes, the Fund will incur another $15 Million loss in 2005 (on top of the $7 Million loss in 2004) and has projected a staggering $23 Million deficit in Plan Year 2006 if remedial measures are not taken immediately***. This situation has required the Trustees, with great reluctance, to make the changes that follow; but ultimately these changes are necessary to stabilize the Fund's finances and protect your future benefits.

Important Pull-Out Section in this issue . . . .

Plan Year 2004 Summary Annual Reports for the Health & Welfare and Pension Funds

The changes decided upon by the Trustees fall into eight categories, all of which will take effect on September 1, 2005, with the exception of the changes to the eligibility requirements, which will take effect October 1, 2005. These areas are:

- Eligibility provisions
- Coordination of Benefit Provisions
- Primary/Specialist Office Visit Copayments
- Outpatient Rehab/Restorative Therapy Copayments
- Deductible and Coinsurance for Hospital, Surgical, Anesthesia, Diagnostic, Laboratory and X-ray Benefits
- Dental Benefit Copayments
- Prescription Drug Benefit Program Changes
- Disease Management Program

A detailed description of each of these changes follows.

We have made every effort to accurately, and completely, explain the benefit changes effective in September and October 2005. If there are any discrepancies between this Summary Document and the Health and Welfare Plan, the Health and Welfare Plan will be the controlling document in determining your benefits.

The Health & Welfare Fund's Summary Plan Description is now in the process of being updated to reflect these changes. It will be printed and published in late July and, at that time, will be mailed to members' homes. Be sure that we have your current address on file. We will also place the updated Summary Plan Description on the Fund's web site.

Eligibility

At present, a member must work at least 15 days in a qualifying month, or 180 days in a qualifying year to be eligible for benefits in a subsequent benefit month. For example, to be eligible for benefits in February 2005, a member needed to work at least 15 days in the month of December 2004 or 180 days from January 1, to December 31, 2004. (This lag is necessary because the hours you may work in December are not reported to us until the end of January, and are then used to determine eligibility for the coming month (February). Similarly, hours you worked in January of 2005, are not reported to us until the end of February 2005, and are used to determine eligibility for the month of March, 2005.)

Effective with eligibility for the month of October 2005, a member must work at least 18 days in the qualifying month, or 216 days in the qualifying year to be eligible for benefits in a subsequent benefit month.

Emergency Room Visit Copayment

Under both the Personal Choice PPO and the Keystone HMO programs, the patient copayment for an emergency room visit will increase from $40 to $150. This copayment will be waived if the patient is admitted to the hospital.

Coordination of Benefits

At present, if a spouse of a member is employed and is offered health care coverage through his/her employer, the spouse need not enroll in that coverage if he/she had to pay any portion of the premium for that coverage.

Beginning September 1, 2005, working spouses of members will be required to enroll in their employer's health plan for their coverage, even if they must pay a portion of the premium. They need not take coverage for dependent children, unless it is provided to them without charge.

The spouse's employer's plan will provide primary coverage for the spouse's claims; the Fund's plan will be secondary.

If there is an open enrollment period for the spouse's plan, the Fund will extend a grace period for primary coverage until that next open enrollment period.

Primary/Specialist Office Visit Copayments

Effective with office visits occurring on and after September 1, 2005, under the Personal Choice PPO program, patient copayments for a primary doctor office visit will increase from $10 to $15 and from $15 to $25 for a specialist office visit. For those participants enrolled in the Keystone HMO program, the primary doctor office visit will increase from $5 to $10, and a specialist office visit from $10 to $20.

Deductible and Coinsurance

Effective with services rendered on and after September 1, 2005, a patient deductible of $250 per year (maximum of $500 per family) will apply for those services not otherwise covered by a copayment (for example, doctor office visits, emergency room visits, outpatient therapy visits). The patient deductible will apply to hospital, surgical, anesthesia, diagnostic, laboratory and x-ray services.

If the deductible is satisfied in the last three months of the Plan Year, it is carried over to satisfy the deductible for the following Plan Year.

After the deductible is satisfied, a patient copayment of 10% will apply up to the next $5,000 in allowed charges for these services. Once the out-of-pocket coinsurance maximum of $500 for that patient is reached, the balance of allowed charges for that patient will be covered at 100% for these balance of the Plan Year.

The out-of-network deductible under the Personal Choice PPO program will also change from $1,200 per person, per year (maximum of $2,400 per family) to $1,500 per person, per year (maximum of $3,000 per family). The patient coinsurance for out-of-network charges will remain the same at 20%.

Outpatient Therapy Treatments

Effective with medical treatments rendered on and after September 1, 2005, for those enrolled in the Personal Choice PPO program, the patient copayment for outpatient rehab/restorative therapies (such as cardiac rehab, speech and language pathology, occupational therapy, physical therapy chiropractic, etc.) will increase from $15 to $25 per session.

Dental Program Benefit Copayments

Effective with dental services rendered on and after September 1, 2005, the following patient copayments will apply:

- Crowns, bridges, etc. $30 per tooth
- Partial/full dentures $50 per unit
- Periodontal Surgery $25 per quadrant
- Endodontic Surgery (root canal) $25 per tooth
- Oral Surgery $25 per tooth
- Orthodontics $100 per case

With respect to orthodontic services, the $100 per case copayment shall apply on to new cases started on or after September 1, 2005. There will be no copayments for preventative and restorative services (routine checkups, cleanings, x-rays, periodontal maintenance). In addition, bleaching is no longer a covered benefit (effective July 1, 2005).

Remember to maximize your benefits and minimize your out-of-pocket dental expense by using a Dental PPO provider. A listing of participating providers is available from the Fund office or on the Fund's web site.

Prescription Drug Program

Beginning September 1, 2005, the Fund will utilize the services of Express Scripts, Inc. to administer the Fund's Prescription Drug Benefit Program. New identification cards and introductory material will be sent to members during the last week in August.

Also, at that same time both the formulary (preferred brand name) and copayment structure will change. Express Scripts is now in the process of comparing the old formulary listing and the preferred drugs you may have been dispensed with the new listing. It will then send letters to members who may be affected by the formulary change so that they will have an opportunity to discuss those changes with their doctor.

The copayment structure will change as follows:

	From	To
Generic drugs	$3	$3
Preferred brand	$10	$10
Non-Preferred brand	$20	} 50%
Proton Pump Inhibitors	$30	} min copay $30
Non-sedating Antihistamines	$30	}max copay $40

Disease Management Program

In April 2004, the Fund initiated a voluntary Disease Management program, known as HealthReach. The purpose of the program is to educate members and their families concerning their individual health issues and, at the same time, monitor the quality of care our participants are receiving to be sure that they are getting the best service for the dollars the Fund and participants are spending for health care.

Based upon claims filed with the Fund, a HealthReach Care Counselor (a Registered Nurse) from HealthCare Strategies, the Fund's Disease Management vendor, contacts the patient to ensure that the patient understands his/her medical condition and helps to coordinate their health care needs. Educational materials are provided to the patient. In some cases, the Care Counselor will contact the patient's treating doctors.

The program has shown proven benefits and successes in those cases where the patient participates in the program. However, in many cases, efforts to help members have been ignored by the patients involved. Their medical conditions have worsened, their overall health has been jeopardized and unnecessary health care dollars have been spent.

The Trustees have evaluated the benefits of the program and have decided that participation in the program will be MANDATORY. **Effective September 1, 2005, the patient will be REQUIRED to participate in the HealthReach program to assure that the Fund is paying for appropriate services. If the patient refuses to contact the HealthReach Care Counselor, a $500 penalty deductible will be applied to charges received after the patient receives final notice to contact the HealthReach Care Counselor**.

IMPORTANT!

This Newsletter contains a summary of Health & Welfare plan changes that will take effect September 1st and October 1, 2005. Please read this material immediately. Keep it for future reference. These changes concern:

- ***the eligibility provisions of the Plan,***
- ***the Fund's Disease Management Program,***
- ***The Plan's Coordination of Benefits provisions, and***
- ***Medical, Dental and Prescription Drug copayments***

Our Member Service Department representatives are available Monday through Friday, 8 a.m. to 5 p.m. to answer any questions you may have about your benefit coverage.

Call us at 1-800-523-2846 or email us at claims@teamsterfunds.com.

Find us on the World Wide Web at www.teamsterfunds.com

Teamsters Health & Welfare and Pension Trust Funds
of Philadelphia and Vicinity
4th & Cherry Streets
Philadelphia, PA 19106

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of Philadelphia and Vicinity

4TH AND CHERRY STREETS • PHILADELPHIA, PA 19106-1899 • (215) 923-6300

TOLL-FREE 1-800-523-2846 • FAX (215) 931-1132 • www.teamsterfunds.com

ADMINISTRATOR
WILLIAM J. EINHORN

UNION TRUSTEES
PAUL CARDULLO
WILLIAM HAMILTON, JR.
ATHONY F. VOLPE

EMPLOYER TRUSTEES
ARNOLD S. ROSENTHAL
KENNETH F. LEEDY
BOB SCHAEFFER

SUMMARY ANNUAL REPORT FOR TEAMSTERS HEALTH & WELFARE FUND OF PHILADELPHIA & VICINITY

This is a summary of the Annual Report of the TEAMSTERS HEALTH & WELFARE FUND OF PHILADELPHIA & VICINITY (Employer Identification Number 23-1392600) for the plan year ending December 31, 2004. The Annual Report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The plan has a contract with THE UNION LABOR LIFE INSURANCE COMPANY to pay certain death claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2004 were $364,545. Because they are so called "experience-rated" contracts, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending 12/31/2004, the retention charges paid under such "experience-rated" contracts were $62,945 and the total of all benefit claims paid under these experience-rated contracts during the plan year was $301,600.

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was ($12,278,839) as of the end of plan year, compared to ($4,399,593) as of the beginning of the plan year. During the plan year the plan experienced a change (decrease) in its net assets of $7,879,246. This change includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of $92,638,030 including employer contributions of $87,712,828, employee contributions of $1,924,525 and earnings from investments of $3,000,677. Plan expenses were $100,517,276. These expenses included $3,234,802 in administrative expenses and $97,282,474 in benefits paid to participants and beneficiaries.

Your Rights to Additional Information

You have the right to receive a copy of the full Annual Report, or any part thereof, on request. The following items are included in that report: (1) An accountant's report; (2) Financial information and information on payments to service providers; (3) Assets held for investment; (4) Loans or other obligations in default or classified as uncollectible; (5) Transactions in excess of 5% of the plan assets; and (6) Insurance information including sales commissions paid by insurance carriers.

To obtain a copy of the full Annual Report, or any part thereof, write or call the office of TEAMSTERS HEALTH & WELFARE FUND OF PHILADELPHIA & VICINITY, Attention William J. Einhorn, Plan Administrator, 4TH & CHERRY STREETS , PHILADELPHIA, PA 19106 and phone number, 215-923-6300. The charge to cover copying costs will be $5.00 for the full Annual Report, or $0.10 per page for any part thereof.

You also have the right to receive from the Plan Administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full Annual Report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the Annual Report at the main office of the plan: 4TH & CHERRY STREETS , PHILADELPHIA, PA 19106, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

William J. Einhorn, Administrator

Teamsters Pension Trust Fund
of Philadelphia and Vicinity

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SUMMARY ANNUAL REPORT FOR TEAMSTERS PENSION TRUST FUND OF PHILADELPHIA & VICINITY

This is a summary of the Annual Report for the TEAMSTERS PENSION TRUST FUND OF PHILADELPHIA & VICINITY (Employer Identification Number 23-1511735) for the plan year ending December 31, 2004. The Annual Report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

Benefits under the plan are provided by a trust fund. Plan expenses were $121,841,731. These expenses included $6,361,310 in administrative expenses and $115,480,421 in benefits paid to participants and beneficiaries. A total of 26,964 persons were participants in or beneficiaries of the plan at the end of the plan year, although not all of these persons had yet earned the right to receive benefits.

The value of plan assets, after subtracting liabilities of the plan, was $1,345,276,645 as of the end of the plan year, compared to $1,246,938,897 as of the beginning of the plan year. During the plan year the plan experienced a change (increase) in its net assets of $98,337,748. This change includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. The plan had total income of $220,179,479, including employer contributions of $81,697,831, gains/(losses) of $23,325,264 from the sale of assets, and earnings from investments of $115,156,384.

Minimum Funding Standards

An actuary's statement shows that enough money was contributed to the plan to keep it funded in accordance with the minimum funding standards of ERISA.

Your Rights to Additional Information

You have the right to receive a copy of the full Annual Report, or any part thereof, on request. The following items are included in that report: (1) an accountant's report; (2) financial information and information on payments to service providers; (3) assets held for investment; (4) loans or other obligations in default or classified as uncollectible; (5) transactions in excess of 5% of the plan assets; and (6) actuarial information regarding the funding of the plan.

To obtain a copy of the full Annual Report, or any part thereof, write or call the office of TEAMSTERS PENSION TRUST FUND OF PHILADELPHIA & VICINITY, Attention: William J. Einhorn, Plan Administrator, 4TH & CHERRY STREETS , PHILADELPHIA, PA 19106 and phone number, 215-923-6300. The charge to cover copying costs will be $5.00 for the full annual report, or $0.10 per page for any part thereof.

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William J. Einhorn, Plan Administrator