PHILADELPHIA Update

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of Philadelphia and Vicinity

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Yearly Open Enrollment Period to Begin This Month

Your Chance to Choose Between Blue Cross PPO or Aetna HMO Coverage

This month, the Fund will begin its annual open enrollment period under the Plan's Double Option feature. This is the opportunity where you, and you alone, get to make the most important decision about your family's health care coverage for the coming year.

This Newsletter outlines, in a general fashion, the coverages available to you and your family under the Fund's *Blue Card PPO* and the Aetna HMO program. If, after reading the general benefit comparison printed on the next page, you are interested in obtaining more information about either of the two plans, you should contact the Fund office to obtain more information with regard to the PPO and HMO options.

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 January 1, 2011 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 January 1, 2011, 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.

If you have Aetna HMO coverage now and want to keep that HMO coverage into next year, you don't have to do a thing. If you have HMO coverage now and don't do anything, as of January 1, 2011 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 January 1, 2011, 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).*

Whether:
• you want to change from PPO coverage to HMO coverage
or
• you want to change from HMO coverage to PPO coverage

for the 2011 Plan Year, you must act NOW!
Cut-off is December 9th

And, best of all, if the coverage you select doesn't work out for you and your family, you'll have this same opportunity to make a change this time next year.

For the current open enrollment period, the cut-off date will be DECEMBER 9, 2010 and the effective date of your new coverage will be JANUARY 1, 2011. This means your application for a change in coverage must be received in the Fund office by the close of business on Thursday, December 9th. Unfortunately, given the time constraints to make all of the necessary changes to everyone's coverages to be effective January 1st, *no exceptions will be made to the December 9h deadline.*

As always, regardless of the option you select, your coverage for Behavioral Health (remember to contact Total Care Network at 1-800-298-2299 to coordinate services), Weekly Disability Benefits, Prescription Drugs, Vision Care, Dental and Death Benefits will still be processed through the Fund, regardless of whether you choose the PPO or HMO option. With the exception of medications which are purchased directly with your Express Scripts Prescription Drug Card, all claims for reimbursement of these benefits should be sent directly to the Fund office for processing.

Don't forget, your last chance for making a change for next year's healthcare coverage is DECEMBER 9, 2010; don't let your time run out!

Also in this Issue . . . . .

TEAMSTERS HEALTH & WELFARE FUND OF PHILADELPHIA & VICINITY

OVERVIEW OF HEALTH BENEFIT PLANS
BlueCard PPO PROGRAM versus AETNA HMO PROGRAM

	BlueCard PPO PROGRAM		AETNA HMO PROGRAM
TYPE OF PLAN:	**Freedom to choose your own doctors and hospitals. You can maximize your coverage and minimize your out-of-pocket costs by choosing Network providers.**		**Your primary care physician coordinates all of your care. Your Aetna Primary Care Physician may also refer you to other Aetna providers for care, if needed. NO coverage Out-of-Network, except for emergency care.**
	In Network	Out of Network*	In Network Only
Deductible (Individual/Family)	$225/$450	$500/$1,000	None
Out-of-Pocket Maximum - Per Person	$500	$1,500	$440 Annual Co-Pay Maximum per Person
Lifetime Maximum	$2 Million	$2 Million	$2 Million
Coinsurance - Plan Pays	90% (100% after Out-of-Pocket Maximum is reached)	80%	100%
Primary Care Office Visit Copay	$15, No deductible	80%, after deductible	$10
Specialist Office Visit Copay	$25, No deductible	80%, after deductible	$20
Maternity Care: - First OB Visit	$15, No deductible	80%, after deductible	$20
Hospital Care - Maternity	90%, after deductible **	80%, after deductible	100%
Inpatient Hospital Services	90%, after deductible **	80%, after deductible	100%
Inpatient Hospital Days	365	70	Unlimited
Out-Patient Surgery	90%, after deductible **	80%, after deductible	100%
Emergency Room Copay (Waived if Admitted)	$100, No deductible	$100, No deductible	$100
Skilled Nursing Facility	90%, after deductible **	80%, after deductible	100% up to 180 days per calendar year
Out-Patient Radiology & Laboratory	1st $100 of allowable lab charges covered @ 100%, then 90%, after	80%, after deductible	100%
Physical, Speech, Occ. Therapy Co-pay per visit	$25, No deductible	80%, after deductible	100% - up to 60 consecutive days per condition covered, subject to significant improvement
Durable Medical Equipment and Prosthetics	90%, after deductible **	80%, after deductible	100% when authorized by Primary Care Physician and approved by Aetna

**NOTE: ***Out-of Network, non-participating providers may bill you for differences between the Plan allowance, which is the amount paid by the PPO, and the provider's actual charge. This amount may be significant. **Plan pays 100% of the allowable charges after the $500 yearly out-of-pocket maximum for that patient is reached.

PLEASE NOTE THAT THE ABOVE BENEFIT OUTLINE IS MEANT ONLY TO HIGHLIGHT KEY FEATURES OF THE PLANS. PRE-AUTHORIZATION MAY BE REQUIRED FOR MANY OF THE SERVICES PROVIDED. REFER TO THE BENEFIT BOOKLET FOR MORE DETAILS ABOUT THE BENEFIT PROGRAM, AS WELL AS EXCLUSIONS AND LIMITATIONS.

Notice of "Grandfathered" Status under the Health Care Reform Act

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, 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 Affordable Care Act 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 Affordable Care Act, for example, the elimination of life-time 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 William Einhorn, the Plan Administrator at the following address: Teamsters Health & Welfare Fund of Philadelphia and Vicinity, 6981 North Park Drive, Suite 400, Pennsauken, NJ 08109

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.

New Rules for Members' Children Under the Age of 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Plan of Benefits of the Teamsters Health & Welfare Fund of Philadelphia and Vicinity. Individuals may request enrollment for such children for 30 days from the date of this notice (provided said adult child is not eligible for other employer-sponsored health plan coverage other than through the Plan covering the member's spouse). Enrollment will be effective retroactively to January 1, 2011. For more information contact the Fund office at 1-800-523-2846.

For more information on this topic, see the "Questions and Answers" section on the next page

What's New For 2011?

With the passage of health care reform, two important changes will occur in 2011 regarding your plan coverage.

- *The $2 Million per patient lifetime benefit limit for medical & prescription benefits will be replaced by a $2 Million **annual benefit limit**.*
- *Your children over the age of 19 can remain covered under your coverage up to age 26, provided that they are not eligible for coverage under any other employer-sponsored group health coverage (other than coverage through the child's other parent).*

Attention Health & Welfare Fund Participants:
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.

Fund to Cover Dependent Children to Age 26 beginning January 1, 2011

Starting with plan years beginning after September 23, 2010, the health care reform legislation that was enacted into law earlier this year requires health plans (even those enjoying "grandfathered" status) that provide coverage for dependent children to allow such children to remain covered until age 26 if certain conditions are met. The questions and answers set forth below are designed to address most of the commonly-asked questions on this subject.

Who can be covered in 2010?

Coverage continues for adult children who were on Fund coverage as of December 31, 2010, and who do not have access to employer-sponsored health care coverage (even if they are married).

For example, if your adult child who turns age 19 (or age 23 if a student) after January 1, 2011 and does not have health care coverage through their employer, he or she will not be terminated from the Fund's coverage because they reached age 19 (or age 23 if a full-time student).

What do I need to do to continue coverage for my adult child?

You must complete an Attestation Form (available from the Fund office or on the Fund's web site) by January 31, 2011. Attestation Forms will continue to be mailed to dependents turning age 19 (or age 23 if a student) in advance of the dependent's birthday.

My son is offered health care benefits through his employer. Is he eligible to enroll in my coverage under the Fund?

No, if your son is offered employer-group coverage through his own employer, he is not eligible to be covered on your plan.

My daughter, age 21, has not been on Fund coverage for almost a year. She will be going back to college in January 2011. Can I add her to my coverage?

You may add your daughter effective January 1, 2011. You must provide proof of full-time enrollment from the College Registrar's office. If she is not a full-time student, you must complete an Attestation Form.

When can I add my dependent child who was not on my coverage on December 31, 2010?

You will be able to add your dependent child to age 26 on and after January 1, 2011.

Is COBRA coverage available for my child over the age of 26?

Yes, but only if the child was eligible on and after January 1, 2011. For example, if your child turned age 26 in 2010, he or she would not be eligible for COBRA coverage by reason of the new law. If, however, he or she was age 25 as of January 1, 2011, enrolled in 2011 and then turned age 26 in 2011 or thereafter, COBRA coverage would be available upon payment of the required COBRA premium.

SUMMARY ANNUAL REPORT FOR
BOARD OF TRUSTEES OF TEAMSTERS HEALTH & WELFARE FUND

This is a summary of the annual report of the Board of Trustees of Teamsters Health & Welfare Fund of Philadelphia and Vicinity, a health, dental, vision, temporary disability and death benefits plan (employer identification number 23-1392600), for the plan year 01/01/2009 through 12/31/2009. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

The Board of Trustees of Teamsters Health & Welfare Fund of Philadelphia and Vicinity has committed itself to pay certain dental, prescription, vision, medical, disability claims incurred under the terms of the plan.

Insurance Information

The plan has a contract with The Union Labor Life Insurance Company to pay certain death benefits claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2009 were $628,862.

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $47,058,222 as of the end of plan year, compared to $32,321,240 as of the beginning of the plan year. During the plan year the plan experienced a change in its net assets of $14,736,982. 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 $106,518,769 including employer contributions of $95,863,375, employee contributions of $2,063,554, earnings from investments of $8,588,437, and other income of $3,403. Plan expenses were $91,781,787. These expenses included $6,554,730 in administrative expenses and $85,227,057 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 items listed below 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 percent of the plan assets. 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 William J. Einhorn, who is a representative of the plan administrator at 6981 North Park Drive, Suite 400, Pennsauken, NJ 08109 and phone number, 856-382-2400. 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: 6981 North Park Drive, Suite 400, Pennsauken, NJ 08109 , 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

Important Notices in this Newsletter about:

- *Health Benefit Plan open enrollment—time is limited; you must act now!*
- Summary Annual Report for the H&W Fund for the 2009 Plan Year
- *Healthcare Reform and its effect on your benefit plan coverage*

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