The Philadelphia Update

Teamsters Health & Welfare & Pension Funds of Philadelphia & Vicinity

A New Look & A Renewed Effort to Communicate in 2014!

You may have noticed that the Summer newsletter looks different. New years call for new resolutions. This year, the Funds have resolved to enhance their communications with you, their members. Your benefits are valuable, and we want to make sure you are aware of and taking full advantage of them!

In addition to publishing this newsletter, the Funds have established a presence on Facebook and Twitter, and have created a blog. The Funds' Facebook, Twitter, and blog accounts are regularly updated with important information about the Funds, your benefits, the Fund Office, and other interesting information. Be sure to follow them today!

Twitter: @TeamsterFunds

Facebook: http://www.Facebook.com/TeamsterFunds

Blog: http://teamsterfunds.wordpress.com

Members Should Update Their Personal Information

The Health & Welfare Fund needs your help in obtaining updated information about its members. If your address has changed, if you have gotten married, separated, divorced, or had children, you are required to notify the Fund of these changes as they will affect your benefits. The Funds cannot extend Health & Welfare benefits to your spouse or children if it does not know about them!

Updating your personal information is easy. You can either download a new Census Card from the Fund's website at http://www.teamsterfunds.com, or call the Fund office and ask that one be mailed to you. Once you have completed an updated Census Card, simply mail it back to the Fund office, and the Fund's personnel will update your information as necessary.

If you have any questions, please call the Member Services department at 800-523-2846 or 856-382-2400 and select option number 1, or send an email to census@teamsterfunds.com.

Key Fund Office Telephone Numbers

Main Switchboard: (856) 382-2400

Health & Welfare Department: Option 1

Pension Department: Option 2

Toll Free: (800) 523-2846

Hours: Mon-Tues, Thurs-Fri: 7:30 a.m. to 5:00 p.m.

Wed: 8:00 a.m. to 8:00 p.m.

Shingles Vaccination Now Covered

The Health & Welfare Fund now covers the Shingles vaccine for members age 60 and over. The vaccine must be acquired through OptumRx. The vaccine is subject to a $25 copayment. Additional copayments and coinsurance may be applicable to the administration of the vaccine by a doctor.

Deployed & Returning Servicemen Should Contact the Fund Office Immediately: The Funds Need to Know to Your Military Status to Protect Your Rights

If you are a Member of any of the United States Uniformed Services (i.e., Army, Navy, Air Force, Marines, Coast Guard, and Public Health Service), and you are deployed on active duty, you have certain rights to continue or suspend your health and welfare benefits. Those rights are governed under the Uniformed Services Employment and Reemployment Rights Act, which is commonly referred to as "USERRA." Because the Health & Welfare Fund is a "multiemployer plan," your USERRA continuation rights differ slightly from those provided under a "single employer plan."

Generally speaking, and assuming your Employer is not required to make contributions on your behalf during your deployment, you have three (3) separate options regarding your health and welfare benefits during a period of active duty with one of the Uniformed Services. Details regarding those options are available in the Health & Welfare Fund's Summary Plan Description, which has been mailed to all Health & Welfare Fund members and is available on the Fund's website. REGARDLESS OF WHICH OPTION YOU CHOOSE TO ELECT, IT IS CRITICALLY IMPORTANT THAT YOU AND YOUR EMPLOYER CONTACT THE FUND OFFICE TO NOTIFY US OF YOUR DEPLOYMENT AND THAT YOU DISCUSS YOUR CONTINUATION OPTIONS WITH ONE OF THE FUND'S MEMBER SERVICE REPRESENTATIVES.

Ask the Administrator: Bill Answers Your Questions

Q1: How are the Pension and Health & Welfare Funds doing financially?

A1: Both Funds are doing well. The Health & Welfare Fund experienced strong investment returns last year and has built up about a ten month reserve of cash. At the same time, the Health & Welfare Fund's costs increased by less than 5% last year, which is great. That having been said, the Health and Welfare Fund's costs will continue to increase in the coming years as a result of the ongoing implementation of the the Affordable Care Act, also known as "Obamacare." The Health and Welfare Fund is in a good position to address those costs.

The Pension Fund continues to recover from the global financial crisis that began in 2008. It experienced excellent investment returns in the last few years. At the same time, however, the Fund's liabilities have also continued to grow as more and more of our members begin to retire and those who are retired live longer. As a result, the Pension Fund remains "endangered" under guidelines set by Congress, but its funded percentage continues to improve slowly. The Trustees implemented a funding improvement plan several years ago that will also help to address the Fund's funded percentage. Additional information regarding the Pension Fund's health is available on the Fund website and was mailed to Fund members at the end of April.

Q2: What is "ASP " or "ASP Benefits" and what is its relationship to the Funds?

A2: "ASP" is an acronym for Administrative Service Professionals. ASP is wholly owned by the Pension and Health and Welfare Funds and was created in 2006. It is the entity that performs the day-to-day administrative functions for both Funds. In addition, ASP has several other clients, including the Teamsters Local 929 Retirement Plan. ASP was created to reduce the administrative expenses of the Pension and Health & Welfare Funds and each year the Funds' auditors offer an opinion to the Trustees regarding whether the arrangement continues to benefit both Funds. They have repeatedly opined that it does.

Participation in the Fund's Disease Management Program Benefits Everyone

Since its implementation in September 2005, the Fund's mandatory disease management program has provided tremendous benefits to the Fund's members and the Fund itself. The disease management program is administered by HealthCare Strategies, a company based in Columbia, MD. The program helps to educate members and their families concerning their individual health issues and, at the same time, monitor the quality of care our Members are receiving to be sure that they are getting high quality service from their healthcare providers.

Based upon claims filed with the Fund, a HealthReach Care Counselor (a Registered Nurse) from HealthCare Strategies contacts selected members to ensure that the member understands his or her medical condition and helps to coordinate his or her health care needs. Educational materials are provided to the patient, and in some cases, the Care Counselor will contact the patient's treating doctors. Not all Fund participants are selected for participation in the disease management program. Instead, HealthCare Strategies looks for those participants at high risk for long term conditions, such as high cholesterol, high blood pressure, diabetes, or other significant conditions, to help manage their care. Thus, for example, a member who has a history of high blood pressure, but who has not been to the doctor in over a year or regularly been filling his or her prescriptions for blood pressure medication may be selected to participate in the program.

The disease management program's goal is to ensure that our members are paying attention to their health conditions and receiving any preventative care they may need. It is not intended to be intrusive. It should be empowering. The reason for this approach is simple: an ounce of prevention is worth a pound of cure. If a member is empowered to learn about the risks of his or her high cholesterol, regularly gets it checked so that his or her physician can manage it, and the member remains compliant with his or her treatment, it could help prevent a heart attack down the road. By the same token, treating high cholesterol as a chronic condition is far cheaper for the Fund than paying for a heart attack that may have been preventable. Improving our member's health and reducing the Fund's costs benefits everyone and helps keep the cost of the comprehensive benefits our members enjoy low.

An additional goal of the program is to encourage Fund participants to use all of the "wellness" benefits the Fund provides. These benefits include annual physical exams, mammograms, colonoscopies, and dental cleanings. Each of these benefits is provided at minimal to no cost to eligible participants (see the Fund's plan document for additional details), and help to improve the quality of Fund members' lives.

The disease management program works. In 2005, when the program first became mandatory, many of the most expensive medical conditions the Fund paid for were related to treatable and manageable conditions like diabetes and high blood pressure. Today, because of the disease management program, those conditions cost the Fund significantly less because they are being treated and managed proactively.

Participation in the Disease Management program has been mandatory since September 1, 2005. If a member refuses to participate in the program and engage with the HealthReach Care Counselor, a $500 penalty deductible (in addition to any other applicable deductible, co-insurance or co-payment) will be applied during each Plan Year to medical claims received after the patient receives final notice to contact the HealthReach Care Counselor.

IF YOU WANT MORE INFORMATION:

Member Services (856) 382-2400, Option 1

Healthcare Strategies: 800-582-1535

http://www.hcare.net

https://www.facebook.com/HealthCareStrategiesInc

The Fund Needs Your Authorization to Share Protected Health Information in Many Situations

In many cases, the Health & Welfare Fund cannot share your Protected Health Information ("PHI") without your permission as a result of a federal law commonly referred to as "HIPAA," as well as various state laws. Your PHI includes, for example, certain information regarding your eligibility for Fund benefits, your claims data, and medical records.

Although there is no single format that authorization needs to follow, there are certain elements that any valid authorization must contain. The Fund maintains a standardized HIPAA authorization form on its website (reproduced on the right-hand side of this page) for the benefit of its members to allow the Fund to share your PHI with your permission. The HIPAA Authorization Form should be completed in its entirety before being returned to the Fund office.

There are a variety of situations in which the Fund needs the authorization of a Fund participant to share PHI. Examples include, without limitation:

- Sharing your PHI with your spouse, or other family members;
- Sharing PHI about an adult child with a parent; and
- Sharing claims information or other PHI with your attorney.

There are also a number of situations in which the Fund does not need authorization to share a participant's PHI. This includes when it shares PHI with its "Business Associates," like HealthCare Strategies to facilitate the Fund's disease management program.

If you would like us to share your PHI with someone else, you should contact the Fund office to confirm that an authorization is needed and/or download and complete a copy of the Fund's HIPAA authorization form from its website, http://www.teamsterfunds.com. Likewise, if you have any questions regarding the Fund's privacy practices, you can review the Fund's HIPAA Privacy Practices in your Summary Plan Description, or on the Fund's website.

TEAMSTERS HEALTH & WELFARE FUND
Of Philadelphia and Vicinity

Authorization to Disclose Protected Health Information
[A separate authorization must be used if the authorization is for psychotherapy notes.]

Participant Name: _____ Birth Date: ____/____/____ MM / DD / YR

Address: _____

_____

Home Telephone Number: _____ E-mail: _____
Work Telephone Number: _____

Participant Identification Number and/or Social Security Number: _____

By signing this authorization form I authorize the person(s) and/or organization(s) described below to use and/or disclose my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) in the manner described below. I understand that I am under no obligation to sign this form. I have signed this form voluntarily to document my wishes regarding the use and/or disclosure of the health information described below in Section 1 of this form.

1. Description of Health Information I Authorize to be Used or Disclosed. The following is a specific description of the health information I authorize be used and/or disclosed: (Specify and provide a meaningful description.)

_____

_____

2. I authorize the Teamsters Health & Welfare Fund of Philadelphia and Vicinity ("Health & Welfare Fund"), to use and/or disclose the health information described above in Section 1 of this form.

3. Persons/Organizations Authorized to Receive and/or Use My Health Information. I authorize the following person(s) and/or organization(s) (or classes of persons and/or organizations) to receive my health information from the person(s) and/or organization(s) described in Section 2 above and to use or disclose such information for the purposes listed below in Section 4 of this form. I understand that if the person(s) and/or organization(s) listed below are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.

_____

_____

4. Description of Each Purpose for the Requested Use and/or Disclosure. I authorize my health information to be used and/or disclosed for the following specific purposes:

_____

_____

5. Your Rights with Respect to This Authorization.

5.1 Right to Revoke. I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form I may contact the Health & Welfare Fund's Privacy Officer at 6981 N. Park Drive, Suite 400, Pennsauken, NJ 08109, (856) 382-2400. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) identified in Sections 2 and 3 of this form have already made in reliance upon this authorization.

5.2 Right to Receive Copy of This Authorization. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of it.

6. Expiration of Authorization. This authorization will expire (choose and complete one):

☐ On _____/_____/_____.
MM / DD / YR

☐ Upon the occurrence of the following event(s) related to my health care or to the purpose(s) for which I have authorized the use and/or disclosure of my health information described in Section 4 of this form:

_____

I, _____ (please print name), have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

_____ ____/____/____
Participant Signature Date

If signed by a personal representative, complete the following:

Name of personal representative: _____

Relationship to participant or nature of authority (e.g., health care power of attorney, parent of child under the age of 18, guardian, other statutory authorization): _____

Address: _____

_____

_____

Home Telephone Number: _____ E-mail: _____
Work Telephone Number: _____

_____ ____/____/____
Signature of Personal Representative Date

If You Participate in the PPO Program, You Should Use Your HCSC Benefit

Several years ago, the Fund contracted with Health Care Solutions Corporation ("HCSC") to provide PPO participants with a very valuable tool to save money on lab work, radiology exams, and diabetic testing supplies. (You are in the PPO program if you are in the Horizon Blue Cross network, as opposed to the Aetna HMO network.) The HCSC program covers all outpatient x-ray, medical imaging procedures, laboratory, pathology and cardiac stress testing. If your doctor has prescribed a covered outpatient medical test, you can save yourself money by using the HCSC outpatient testing benefit program. It's easy, simple and a substantial savings for you and your family.

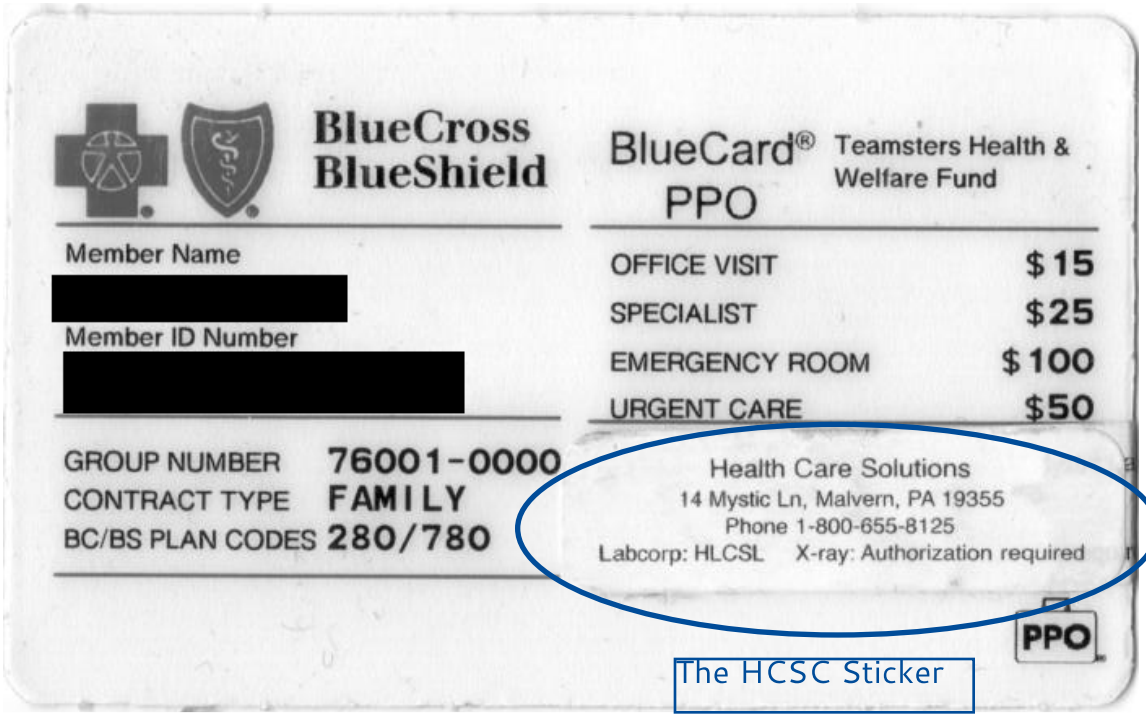
Lab Work: If you use Laboratory Corporation of America (LabCorp) or Quest Diagnostics (Quest), or Health Network Lab facilities for outpatient laboratory services, no deductible, co-insurance or copayments will apply. In other words, you pay nothing! If you a facility other than LabCorp, Quest or Health Network Lab for such services, they will still be covered under the benefit program, but will be subject to the deductible and co-insurance provisions set forth in the Summary Plan Description.

Radiology Examinations: You may obtain outpatient radiology services through the HCSC network of providers. If your doctor asks that you have a radiology examination (e.g., an x-ray, MRI, CT Scan, ultrasound, etc.), call HCSC at 1-800-655-8125 and get precertified by HCSC for the examination in question and a list of participating providers. If HCSC precertifies you, and you use an HCSC network provider, your only out of pocket cost for the examination is $20.00. HCSC's network or participating providers is large and includes facilities such as Jefferson Radiology. If you use non-HCSC facilities for radiology services, they will be covered under the benefit program, but will be subject to the deductible and co-insurance provisions set forth in the Summary Plan Description.

Diabetes Management: If your doctor is treating you for Type I or Type II diabetes, you should contact HCSC for your important diabetic supplies. The Fund has arranged for brand name diabetic testing products to manage your diabetes testing care at a very nominal cost to you. The program covers the following: diabetic test strips; starter kits; test meters (free); syringes, lancets; alcohol swabs; replacement pen needles; and a sharps container.

In order to take advantage of the HCSC program, you should place a HCSC sticker to the back of your Fund health program card (your Horizon Blue Cross/Blue Shield card) and tell the applicable benefit provider to bill the charges through HCSC and not Horizon. Stickers are available in your new Member kit or from the Fund office. If you would like to participate in the diabetes management program, you should contact HCSC directly at 1-800-655-8125.

Finally, please note that you are not required to participate in the HCSC program, but doing so will save you money.



The HCSC Sticker

Understanding Your Healthcare Costs

There are various charges you are responsible for as a plan participant. They go by different names such as "copayment," "coinsurance," and "deductible." We occasionally find that Fund participants do not really understand what these terms mean. That is a shame because understanding what these terms mean is the first step in understanding your benefits, whether you have been billed for them correctly, and their true value.

The following is a list a commonly used terms that describe the types of charges for which each Fund participant is responsible.

Copayments are fixed dollar amounts (for example, $15 for an office visit) you pay for covered health care, usually when you receive the service.

The deductible is the amount you are responsible for paying for any service to which a copayment does not apply before the Fund begins paying for your healthcare.

Coinsurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 10% would be $100. You do not pay coinsurance until after you have already met your deductible.

The out-of-pocket limit is the maximum amount of money you are required to contribute to your healthcare in a given year, excluding copayments.

The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. This is called balance billing.) In-network providers accept the Fund's allowed amount as payment in full.

The amount each participant pays in copayments, deductibles, coinsurance, and the out-of-pocket limit varies depending on whether the participant is enrolled in the HMO or PPO program.

TEAMSTERS HEALTH & WELFARE FUND OF PHILADELPHIA & VICINITY

OVERVIEW OF HEALTH BENEFIT PLANS
PPO PROGRAM versus AETNA HMO PROGRAM

	PPO PROGRAM		AETNA HMO
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 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
Annual Maximum	None	None	None
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; ($50 Urgent Care Center)	$100, No deductible; ($50 Urgent Care Center)	$100; ($50 for Urgent Care Center)
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 deductible **	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 FOR PPO Program: *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. ***Lower or no copays available when using the Healthcare Solutions provider network for outpatient lab (LabCorp or Quest) and xray services.***			
Prescription Drug	30 day supply at retail; $3 generic; $10 preferred brand; 50% non-preferred ($30 min copay, $40 max copay); mail order available for maintenance drugs - 90 day supply = a single copay		
Dental	$2000 per year per patient plus $3400 lifetime orthodontic allowance for children 10-18 years; some copays apply for orthodontic, periodontic,oral surgery, denture, crown, and fixed bridge services; subject to Fund allowances for each dental service		
Vision	One exam every 24 months ($40 exam allowance); frames and lenses once every 24 months; subject to Fund allowance maximums		

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.

Save Yourself from Additional Heartbreak: Separated Spouses are Ineligible for Health & Welfare Fund Benefits

If you and your spouse separate, you are both required to notify the Health and Welfare Fund right away. Although "spouses" are covered dependent beneficiaries under the terms of the Health & Fund's plan document, that term has specifically excluded "separated spouses" for over thirty years. As a result, separated spouses are ineligible for Fund benefits. A married couple will be considered to have "'separated' if they are living separate and apart with an intent to terminate or abandon the marital relationship." The fact that a member and his or her spouse remain legally married, or that the state in which they reside does not recognize the concept of "legal separation" is irrelevant. In addition, the fact that a member is required by state domestic relations laws to maintain health benefits for his or her estranged spouse is also irrelevant.

If the Health & Welfare Fund becomes aware that a member and his or her spouse have separated, several processes will be set in motion. First, the separated spouse's eligibility for Health & Welfare benefits will immediately terminate. The termination of those benefits will be treated as a "qualifying event" that triggers the spouse's right to elect continuation coverage under the Consolidated Omnibus Reconciliation Act of 1986 ("COBRA"). Second, the Health & Welfare Fund's member services representatives will review the separated spouse's claims history to determine if any claims were paid by the Fund during the period of separation. If they were, the Fund will demand repayment of the amounts paid on the separated spouse's behalf during the separation.

The Health & Welfare Fund has several methods for recouping the benefits improperly paid to a separated spouse as a result of the member's or spouse's failure to notify the Fund of their separation. These include requesting that you enter into a payment plan to repay the Fund for the benefits paid and denying payment on claims submitted to the Fund until such time as the claims denied are equal to the amount of the debt owed to the Fund. In certain circumstances, the Fund may also be forced to file a lawsuit against the member and his or her separated spouse to recover the amounts owed.

The easiest step a member or separated spouse can take to avoid this situation is to advise the Fund of your separation as quickly as possible. Doing so will avoid an overpayment of benefits and delays in processing claims for other family members. The Fund's member services personnel will send you the necessary paperwork and take over the process from there.

IN THE NEXT ISSUE:

* 2015 OPEN ENROLLMENT MATERIALS
* TIPS AND RESOURCES FOR IMPROVING YOUR FINANCIAL LITERACY
* USING THE FUNDS' WEBSITE TO CHECK ON YOUR BENEFITS
* A DISCUSSION OF PLAN DEMOGRAPHICS
* MORE QUESTIONS & ANSWERS FROM BILL EINHORN

DO NOT DISCARD!

TEAMSTERS HEALTH & WELFARE & PENSION FUND NEWSLETTER

Stay in touch at www.teamsterfunds.com

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