Important Information
Summary of Recent Changes to Your Benefits Under the
Tri-State Teamsters Health Services and Insurance Plan
Teamsters Plus Plan & Teamsters Part-Time Plan

The Board of Trustees is pleased to announce the following improvements to the Plan of Benefits under the Tri-State Teamsters Health Services and Insurance Plan (the "Plan"). Please read this notice carefully. This notice makes certain changes to your benefits and amends the provisions of your Summary Plan Description (SPD). Please keep a copy with your SPD and share it with your family. The required annual notice concerning the Women's Health and Cancer Rights Act **(WHCRA)** which provides for reconstructive surgery after a mastectomy is also included.

PPACA – Patient Protection and Affordable Care Act

National Health Care reform legislation (called **PPACA** – **Patient Protection and Affordable Care Act**) became law last spring. Health Plans such as those in the Tri-State Teamsters Health Services and Insurance Plan have to comply with PPACA by the beginning of the first Plan Year following September 23, 2010. For the Affiliated Plans of the Tri-State Teamsters Health Services and Insurance Plan, this means we must comply by **July 1, 2011.**

PPACA prohibits Plans from placing annual or lifetime dollar limits on "essential health benefits". "Essential health benefits" are defined as "ambulatory patient services, emergency services, hospitalization, maternity and newborn care, services for mental health and substance abuse disorders including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management and pediatric services including vision and oral care. **PPACA** also prohibits Plans from placing lifetime dollar limits on benefits, in general.

PPACA requires Plans to provide coverage to dependent children until the child turns 26 years of age, regardless of where the children live, if they are "dependents" of the Participant, whether they are in school or not or their marital status. Prior to July 1, 2014, Plans do not have to cover a child from their 19th birthday to their 26th birthday if they have access to employer-sponsored health care (other than through a parent). Please see the **Important Notice – Extending Coverage For Your Children** included in this envelope.

The following changes were made effective retro-active to January 1, 2011:

- The annual limit of $600 was eliminated for the Routine Examination Benefit for Members and Spouses. The Plan will continue to cover an annual visit, including a separate, routine gynecological visit.

- The lifetime benefit limit of $2 million was eliminated and replaced with a $2 million annual benefit limit per individual in calendar years 2011, 2012 and 2013. The annual benefit dollar limit will be eliminated entirely in 2014.

- The lifetime limit of $450,000 on the Organ Transplant Benefit was eliminated. Calendar year limits of $750,000 for 2011, $1.25 million for 2012 and in 2013 the overall annual benefit of $2 million will apply. Annual benefit dollar limits will be removed entirely from 2014 going forward.

Massachusetts Health Care Reform

Effective January 1, 2011, under Massachusetts law (Minimum Creditable Coverage-MCC), group health plans must provide dependent daughters of Participants who are Massachusetts residents with the same maternity coverage extended to Participants or their spouses. If not, all Massachusetts residents on the plan would face a state-imposed penalty of between $14 and $93 per resident per month depending on their income level. This Plan will be modified to meet this requirement.

The following changes are effective July 1, 2011:

Prescription Drug Co-Payments

The current prescription drug co-payments of $5 per generic drug, $15 per single source brand drug (no generic equivalent), and $25 per multi-source brand drug have not changed since July 1, 2003. As the cost of prescription drugs has risen, the Fund has contributed a greater percentage of the cost. Effective July 1, 2011, the following prescription drug co-payments will apply:

Retail*	
Generic drugs	**$10 co-payment**
Single source brand drugs (No generic equivalent)	**$20 co-payment**
Multi-source brand drugs (generic equivalent available)	**$30 co-payment**
Mail Order**	
Generic drugs	**$15 co-payment**
Single source brand drugs (No generic equivalent)	**$35 co-payment**
Multi-source brand drugs - Not available at mail order	

***30 day supply available at retail**
****Mail-order co-payments are for a maximum 90 day supply.**
Co-payments were raised $5 at each level only.

THE FOLLOWING NOTICES RELATE TO PLAN CLARIFICATIONS AND ARE FOR YOUR INFORMATION ONLY

- If a Dependent's eligibility is based on the provision of documentation, he or she will not be eligible for benefits more than 12 months before the Fund Office receives the necessary documentation.

- The pending termination period is four (4) months and the pending termination period is not considered a part of your COBRA coverage period. (**Part-Time Plan Only**)

- Medicare is the primary payor if coverage under the Plan is not based on active employment, and COBRA, by definition is NOT based on active employment. This would not apply if Medicare coverage is due to End Stage Renal Disease (ESRD) during the 30 month coordination period.

- The Plan is secondary to Medicare when a participant is in his pending termination period.

- Effective July 1, 2011, an employer's Voluntary Withdrawal from the Plan is not a qualifying event triggering COBRA eligibility.

Mental Health Parity and Addiction Equity Act of 2008

This legislation requires review and changes to the benefit structure for mental health and substance abuse benefits. **No changes are required to be made to the Plan until July 1, 2014.**

Reminder of the Home Health Equipment Benefit

The Plan provides certain **Durable Medical Equipment,** at no cost to you, with a prescription from your physician. If the required equipment is not available through this benefit, it may be available under the Major Medical Expense Benefit, if prior authorization is obtained.

Please contact either the **Home Health Equipment Department** at **1-203-876-3100 x272** or the **Teamsters Medical Review Program** at **1-800-888-9255** for more information.

Annual Notice Concerning Benefits for Reconstructive Surgery after a Mastectomy

The Women's Health and Cancer Rights Act **(WHCRA)** requires that the Plan inform you that coverage is provided for the reimbursement of expenses associated with reconstructive surgery following a mastectomy, expenses for reconstructive surgery on the other breast to achieve symmetry, the cost of prostheses and costs for treatment of physical complications at any stage of the mastectomy including lymphedemas. The Plan deductible, co-payments and out-of-pocket limits apply. Payment of these expenses will accumulate toward any applicable maximums.

If you have any questions, please contact your Local Fund Office.

Board of Trustees