Teamsters Local 641 Welfare Fund

714 Rahway Avenue, 2nd Floor, Union, New Jersey 07083
Telephone: (908) 687-4488
Fax: (908) 687-8368

April 7, 2008

TO: All Plan Participants

RE: **CLARIFICATION OF PLAN BENEFIT CHANGES**

Dear Participant:

This notice serves to clarify and correct the following recent plan changes effective 4/1/08:

ELIGIBILITY

At the Board of Trustees' meeting held on March 20, 2008, the Trustees decided to amend the Summary of Material Modifications mailed on March 1, 2008 concerning eligibility to read as follows:

Most benefits become effective for you on the first day of the second calendar month immediately following six calendar months (12 months for dental benefits) in each of which you worked at least **ten (10)** days in covered employment. This six-month period must be within 12 months of the first month in which you have worked at least **ten (10)** days. Coverage will continue for the second month following a month in which you work **10** days. Example: you must work at least **10** days in April to be covered for June.

COLORECTAL SCREENINGS

In the schedule of benefits that was mailed on March 10, 2008, colorectal screenings were included as a covered benefit effective 4/1/08. The coverage applies only to the fecal occult blood tests (CPT codes 88270 through 82274). Colonoscopies are not included in this well care benefit. Colonoscopies will be covered only when medically necessary based on acute or recurrent symptomology.

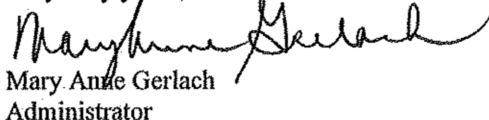
QUEST DIAGNOSTICS

Quest Diagnostics is **NOT** a contracted provider with Horizon Blue Cross Blue Shield of New Jersey and, therefore, will be considered an out of network provider in the State of New Jersey. **LABCORP** and many other free standing diagnostic facilities participate with Horizon Blue Cross Blue Shield of New Jersey. In order to avoid any additional out of pocket expenses, we urge you, as always, to remind your doctor that your coverage is through Horizon PPO and that a participating lab should be used.

For those participants who live out of state, please contact your local Blue Cross Blue Shield to determine which free standing labs participate in your state.

If you have any questions, please feel free to contact this office for assistance.

Very truly yours,



Mary Anne Gerlach
Administrator

TEAMSTERS LOCAL 641 BENEFIT FUND
Group # 9294
Delta Dental PPO℠

Preventive & Diagnostic	80%
* Exams, Cleanings & Bitewing X-rays (each twice in a calendar year)	
* Fluoride Treatment (once in a calendar year, children to age 19)	
Remaining Basic	80%
* Fillings, Extractions	
* Endodontics (root canal)	
* Periodontics, Oral Surgery	
* Sealants	
Crowns & Prosthodontics	80%
* Crowns, Gold Restorations	
* Bridgework	
* Full & Partial Dentures	
* Implants	
* Repair of Dentures	
Calendar Year Maximum (per patient)	$1,000
Orthodontic Benefits (child only)	80%
* Lifetime Maximum (per patient)	$2,500

This program is based upon a network of Delta Dental PPO dental offices, although you may choose any fully licensed dentist to render necessary services. Participating dentists will be paid directly by Delta Dental to the extent that services are covered by the contract. Non-participating dentists will bill the patient directly, and Delta Dental will make payment directly to the subscriber. Patients who select a non-Delta Dental PPO dentist have benefits paid on a Delta Dental PPO schedule of allowances and are responsible for any part of the dentist's fee which exceeds the allowance except that a Delta Dental participating dentist can only charge up to his/her filed fee or Delta Dental's maximum plan allowance, whichever is less. **Maximum benefit may be derived by utilizing the services of a participating Delta Dental PPO dentist.**

Visit a Delta Dental PPO dentist. If you do not have a Delta Dental PPO dentist, there is a directory available with your plan administrator listing Delta Dental PPO dentists. You may call **1-800-DELTA-OK** and a list of participating dentists located in your area will be mailed directly to your home or you may access our Website at www.deltadentalnj.com.

During your FIRST appointment, tell your dentist that you are covered under this program. Give him/her your Group's name, its Delta Dental Group Number and your Social Security number. Your dependents, if covered, should give YOUR SOCIAL SECURITY NUMBER.

If you have any questions regarding your benefits, you may contact our Customer Service Department Monday through Thursday, 8:00 a.m. to 6:30 p.m. EST and Friday, 8:00 a.m. to 5:00 p.m. EST, at 1-800-452-9310.

This overview contains a general description of your dental care program for your use as a convenient reference. Complete details of your program appear in the group contract between your plan sponsor and Delta Dental of New Jersey, Inc. which governs the benefits and operation of your program. The group contract would control if there should be any inconsistency or difference between its provisions and the information in this overview.

U&A ________ December 9, 2008

Teamsters Local 641 Welfare Fund

714 Rahway Avenue, 2nd Floor, Union, New Jersey 07083
Telephone: (908) 687-4488
Fax: (908) 687-8368

SUMMARY OF MATERIAL MODIFICATIONS

TO: Plan Participants
FROM: Plan Trustees
SUBJECT: Occupational Therapy Benefit
Dental Benefits
PLAN EIN: 22-6220289
DISTRIBUTION DATE: December 17, 2008
PLAN NUMBER: 001

OCCUPATIONAL THERAPY BENEFIT

Effective 11/1/08, occupational therapy will be a covered benefit for all participants with medical benefits. The benefit will be limited to 25 visits per year with a $50.00 daily fee limit and will be administered as follows:

In-network free standing facility: $20.00 co-pay – 100% of benefit up to $50.00 daily fee limit;
In-network outpatient hospital: $20.00 co-pay – 100% of benefit up to $50.00 daily fee limit;
Non-network free standing facility: 70%, after yearly deductible, up to $50.00 daily fee limit;
Non-network outpatient hospital: - NOT COVERED

We urge you to contact the Fund office before beginning occupational therapy for more information on what you may expect to pay for the services.

DENTAL BENEFIT CHANGE

For those participants with dental benefits, effective 1/1/09, Teamsters Local 641 Welfare Fund has engaged Delta Dental of New Jersey, Inc. to manage your dental benefits replacing Dentsco as the plan's dental PPO. Any claims you incur or will incur before 1/1/09 will be processed by Dentsco. For any claims you incur on or after 1/1/09, your claims will be processed by Delta Dental of New Jersey, Inc. It is important that you contact your dentist regarding this change in order that you may ascertain whether or not your dentist participates in the **Delta Dental PPO** network and so that your claims will be sent to the correct office for processing.

IN-NETWORK claims for covered services will be paid at 80% of Delta Dental's fee schedule and will be paid directly to your dentist. Your yearly dental maximum remains at $1000.00 per person. You will be responsible for 20% of the contracted charges and all fees incurred after your paid benefit reaches $1000 for the calendar year. An important feature of Delta Dental's program is that a Delta Dental participating dentist cannot charge you more than the contracted fee even when your benefits have been exhausted for the year. You will only be responsible for the contracted fees for charges for services incurred after the plan has paid $1000.00.

(OVER)

OUT-OF NETWORK claims for covered services will be paid at 80% of Delta Dental's fee schedule (not at reasonable and customary rates) and will be paid directly to the insured. You will be responsible for any part of the dentist's fee which exceeds Delta Dental's fee schedule and which exceeds the plan's annual allowance.

By staying in the network you will incur less out of pocket expenses and you will be able to maximize your yearly dental allowance.

Effective 1/1/09 covered dental benefits will be provided for eligible dependent children beginning at age 2.

ORTHODONTIC BENEFITS

Your orthodontic benefit with Delta Dental of New Jersey is still a lifetime benefit of $2500 covered at 100%. Any services started prior to 1/1/09 will be pro-rated subject to the patient's lifetime benefit balance at 12/31/08.

Orthodontic work in Progress before January 1, 2009: Delta Dental will determine the patient's lifetime benefit balance at 12/31/08. Delta will pay ½ of the amount available when the claim is received and the second ½ 12 months later (subject to continuation of the patient's eligibility with the plan). There will no longer be monthly or any other interim payments made.

Orthodontic cases started on or after January 1, 2009: The benefit will be paid in two installments: ½ of the $2500, or $1250, will be paid when the braces are inserted and the second ½ ($1250) will be paid 12 months later (subject to continuation of the patient's eligibility with the plan). There will no longer be monthly or any other interim payments made.

To obtain a list of participating dentists within your geographic area, visit Delta Dental's Web site at: www.deltadentalnj.com and click the dentist search link under Find a Dentist. Please be sure to search for a **Delta Dental PPO** dentist. Delta has other providers that are not part of the PPO panel. If you incur charges for services rendered by a non-PPO Delta dentist, your out of pocket expense may be significantly greater. You may also call 1-800-DELTA-OK and a list will be mailed to your home. For those participants with dental benefits, we have enclosed a set of ID cards for your new dental plan.

Please contact the Fund office for any questions you have regarding these plan changes.

Very truly yours,

Mary Anne Gerlach
Plan Manager
FOR THE BOARD OF TRUSTEE

Teamsters Local 641 Welfare Fund

714 Rahway Avenue, 2nd Floor, Union, New Jersey 07083
Telephone: (908) 687-4488
Fax: (908) 687-8368

SUMMARY OF MATERIAL MODIFICATIONS

TO: Plan Participants
FROM: Plan Trustees
SUBJECT: **DENTAL BENEFITS/SPD CLARIFICATIONS** PLAN EIN:22-6220289
DISTRIBUTION DATE: April 2, 2009 PLAN NO: 501

DENTSCO DENTAL CLAIMS – CHANGE IN TIMELY FILING PERIOD

All claims for **dental services** incurred **prior to 1/1/09** must be filed with Dentsco by no later than **June 30, 2009**. The Plan's normal one year timely filing period has been changed for this benefit only. Any claims received by Dentsco after June 30, 2009 will not be covered.

All other plan benefits will still have a one year timely filing period.

DELTA DENTAL PPO BENEFITS - IMPORTANT INFORMATION

It has come to our attention that participants are sometimes unclear about the Delta Dental PPO program. In particular, some dentists participate in another Delta program (the Premier plan) and not in the PPO program but this distinction is not always explained to the patient. The schedule of benefits for the PPO plan is totally different than the schedule of benefits for the Premier only plan. If the dentist only participates in the Delta premier network, your out of pocket will be substantially larger than what you would incur for services provided by a dentist who also participates in Delta's PPO network.

When calling a provider's office to see if they participate with Delta Dental, you **must also ask** if the dental office participates in the **Delta PPO** Program. Dental offices will "accept" any insurance but they may also balance bill you for the greater fee schedule if they do not "participate" in the Delta PPO Program.

To ensure your provider participates in the Delta PPO Program, you can also:

1. Contact Delta's Customer Service at: 1-800-452-9310
2. Visit Delta's website at www.deltadentalnj.com or
3. Call 1-800-DELTAOK (1-800-335-8265) and a list of PPO providers will be mailed to your home based on the zip code you provide.

Choosing a participating PPO provider will provide you the best benefit and least out of pocket expense.

(OVER)

APRIL, 2008 SUMMARY PLAN DESCRIPTION CLARIFICATIONS:

REASONABLE AND CUSTOMARY LIMITS. It is important to note that **all benefits** payable under Teamsters Local 641 Welfare Fund **are subject to reasonable and customary limits.**

LIFETIME MEDICAL BENEFIT RESTORATIONS: No more than $100,000 is payable for medical benefits for most expenses incurred during any one person's lifetime. Not applied toward your lifetime medical maximum benefit are the routine vision benefit, hearing aid benefit and the Express Script drug card benefit. Also not applied toward your lifetime medical maximum benefit are any hospital **facility** benefits paid while you are an **in-patient** (please note that this means any charges the hospital bills for while you are an in-patient).

On January 1 of each year, the amount of the benefits which became payable in the past but which were not previously restored will be automatically restored except that:

(1) the maximum amount restored for each person in any year shall be $10,000; and

(2) such restoration will not apply to any retired participant or any retired participant's dependent, nor during any extension of benefits, nor to any person after the total amount automatically restored for that person reaches $100,000.

If you have any questions, please feel free to contact the Fund office for assistance.

Very truly yours,

Mary Anne Gerlach
Plan Manager
FOR THE BOARD OF TRUSTEES

Teamsters Local 641 Welfare Fund

714 Rahway Avenue, 2nd Floor, Union, New Jersey 07083
Telephone: (908) 687-4488
Fax: (908) 687-8368

Summary Of Material Modifications

To: **Plan Participants**

From: **Plan Trustees**

Subject: **Exclusion for Automobile related expenses**

Date: **March 29, 2010**

Ein: **226220289**
Plan Number: 501

Dear Participant:

Effective May 1, 2010 the Plan will not pay for any benefits or services rendered for the treatment of automobile related accidents, injuries or illnesses. The plan will also not pay for deductibles, coinsurances or co-payments for automobile related accidents, injuries, or illnesses.

****IMPORTANT**** *You **should not** be advising your automobile insurance carrier that you have alternative coverage through Teamsters Local 641 Welfare Fund for medical claims arising from an automobile accident.*

If you have any questions, please contact the Fund Office.

Sincerely,

The Board of Trustees

For the Union:

William Cunningham
Anthony Artificio, Jr.
Jan Katz

For the Employers:

David Mazzella
John Kerins

Teamsters Local 641 Welfare Fund

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NOTICE OF SPECIAL OPPORTUNITY TO ENROLL ADULT CHILDREN

December 28, 2010

Dear Participant,

As you may know, the new health reform law requires group health plans that provide coverage to children of participants to provide coverage until the children attain age 26. In addition, until 2014, group health plans that are "grandfathered health plans" under the new law are allowed to exclude from coverage any child of a participant who is eligible for employer-sponsored coverage through the child's own employer or the child's spouse's employer.

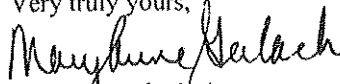
The Welfare Fund in compliance with the new law, is providing a special enrollment opportunity for children of participants whose coverage ended, who were denied coverage, or who were not eligible for coverage, because under the Plan's current rules children ceased to eligible when they turned 19, or later, if they were enrolled in college. Enrollment will be effective as of March 1, 2011. The special enrollment is available only if your adult child is not eligible for employer-sponsored coverage through his or her own employer or a spouse's employer. Note that eligible for coverage does not mean has coverage. If your child can purchase health coverage through his or her own employer or his or her spouse's employer, the child may not enroll in this Plan.

You may enroll your eligible adult children with the enclosed enrollment form. In order to obtain coverage, you must provide the Fund Office with the completed form, as well as a certified copy of a birth certificate for each adult child to be covered. In addition, you must certify that any adult children who are enrolled in the Plan are not now either eligible for or enrolled in other health coverage through their own employment or their spouse's employment. If any adult children become eligible for coverage or actually covered under an employer's health plan in the future, they will no longer be eligible for coverage under this Plan, even if they have not yet attained the age of 26. You must also certify that you will immediately inform the Plan if your adult child becomes eligible for employer-sponsored health coverage through your adult child's employer or his or her spouse's employer, and that you understand that, by failing to inform the Plan, you will be responsible for any claims incurred by the Plan on behalf of an adult child while such adult child was not eligible for benefits under the Plan.

The Plan will have the right to cancel an adult child's coverage retroactively in the case of fraud or an intentional misrepresentation of a material fact and to seek reimbursement for any claims incurred, including by offsetting against your or your family members' medical claims any claims wrongfully paid.

If you have any questions regarding this special enrollment opportunity or the enrollment form, please contact the Fund Office.

Very truly yours,



Mary Anne Gerlach
Plan Manager

Teamsters Local 641 Welfare Fund

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IMPORTANT NOTICE

December 28, 2010

TO: All Plan Participants

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;

- Surgery and reconstruction of the other breast to produce a symmetrical appearance;

- Prostheses; and

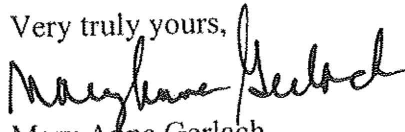
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Please note that our plan already provides coverage for the items listed above and did so prior to the enactment of the Act and will continue to provide such coverage. Nonetheless, federal law requires our plan to notify you of this coverage.

If you have any questions, please feel free to contact us.

Very truly yours,



Mary Anne Gerlach
Plan Manager

Teamsters Local 641 Welfare Fund

714 Rahway Avenue, 2nd Floor, Union, New Jersey 07083
Telephone: (908) 687-4488
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TEAMSTERS LOCAL 641 WELFARE PLAN

SUMMARY OF MATERIAL MODIFICATIONS

TO: Plan Participants

FROM: Board Of Trustees

SUBJECT: Patient Protection and Affordable Care Act (PPACA)

DISTRIBUTION DATE: December 28, 2010

EIN: 226220289
PLAN NUMBER: 501

Dear Participant:

This notice contains important information regarding changes to the Teamsters Local 641 Welfare Fund. Please take the time to read this carefully and share it with your family. Keep this notice with your Welfare Plan documents.

The Board of Trustees of the Plan has made the following changes to the Plan, in order to comply with the requirements of the new health reform law formally known as the Patient Protection and Affordable Care Act of 2010.

Extension of Coverage to Children of Employees up to Age 26

The Board has expanded the Plan's definition of "Eligible Dependent" to include an employee's children up to the attainment of age 26. Effective March 1, 2011, the definition of "Eligible Dependent" will be as follows:

For Eligible Employees, an Eligible Dependent is: a legal spouse of an Eligible Employee; a child of an Eligible Employee if such child is under 26 years of age and a child of an Eligible Employee over 26 years of age who became totally disabled before reaching the age of 26, provided that prior to age 26 he or she was enrolled under this program and is incapable of self-sustaining employment by reason of mental retardation or physical handicap. For your handicapped child to remain covered, you must submit proof of the child's inability to engage in self-sustaining employment by reason of mental retardation or physical handicap within 31 days of the child's attainment of age 26. The proof must be in a form which meets the program's approval. Such proof must be resubmitted every two years within 31 days before or after the child's birth date. The word "child" as used in this definition includes a biological child, a legally adopted child or a child placed with you for adoption, as well as a step-child. No individual will be considered a child of an Eligible Employee unless such Employee has provided the Plan with a certified copy of the child's birth certificate, and other proof of eligibility that may be requested by the Administrator.

(OVER)

Dependent Enrollment Requirement

Effective March 1, 2011, employees will have 30 days to enroll a new dependent as a result of marriage, birth, adoption, or placement for adoption, you will be able to enroll your dependents provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If the fund office is not notified within 30 days of you acquiring a new dependent you will not be able to enroll that dependent until March 1 of the following year. If your dependents are currently not enrolled in the plan because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan provided that you request enrollment within 30 days after your other coverage ends.

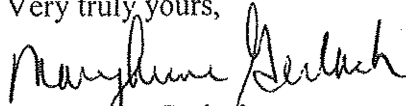
Grandfathered Health Plan

The Teamsters Local 641 Welfare Plan believes this plan or coverage] 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 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 plan administrator at: Teamsters Local 641 Welfare Fund, 714 Rahway Ave., 2nd Fl., Union, NJ 07083 Attn: Mary Anne Gerlach, Plan Manager. 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.

This Summary of Material Modification (SMM) does not restate all of the terms and provisions of the Health and Welfare Plan and does not affect any benefit other than the ones discussed above. All other terms of the Medical Plan, as set forth in the Summary Plan Description remain in effect. The Board of Trustees reserves the right, in its sole and absolute discretion, to interpret and decide all matters under the Plan. The Board also reserves the right in its sole and absolute discretion to amend, modify, or terminate the Plan or any benefits provided under the Plan (or eligibility for such benefits), in whole or in part, for active and retired participants at anytime and for any reason.

If you have any questions concerning these changes or your Welfare Plan benefits, please contact the Fund Office.

Very truly yours,



Mary Anne Gerlach
Plan Manager
FOR THE BOARD OF TRUSTEES

BOARD OF TRUSTEES

For the Union:

William Cunningham
Anthony Artificio, Jr.
Jan Katz

For The Employers:

David Mazzella
John Kerins

Teamsters Local 641 Welfare Fund

714 Rahway Avenue, 2nd Floor, Union, New Jersey 07083
Telephone: (908) 687-4488
Fax: (908) 687-8368

Dear Participant:

Enclosed are your new Horizon Blue Cross Blue Shield of New Jersey ID cards for 2011. **Beginning March 1, 2011, a precertification requirement has been added for certain outpatient radiology/imaging services.**

New precertification requirement

The Fund has entered into an agreement with CareCore National, LLC (CCN) to assist in the management of certain nonemergency outpatient radiology/imaging services. CCN is a physician-owned radiology management service company that will help ensure appropriate use of outpatient radiology/imaging services. For your convenience, the CCN phone number has been included on the back of your new ID card.

What you need to know

AS of March 1, 2011, your Horizon PPO Network physician must call CCN before you receive services on an outpatient basis (includes services done at freestanding radiology facilities) for any of the procedures listed below:

- CT/CTA scans.
- PET/CT.
- PET scans.
- MRI/MRA.
- Nuclear Medicine Studies.
- Nuclear Cardiology Studies.

Please Note: If you do not have the procedure precertified, then the Horizon participating Radiologist will not perform the service. Please ensure that these services are precertified prior to receiving them.

If your physician prescribes radiology/imaging services other than those listed above, then he or she does not need to call CCN to precertify those services.

CAUTION – IF YOU USE A NON-PARTICIPATING REFERRING PHYSICIAN

When using a non-participating referring physician, it will be your responsibility to advise your doctor that the doctor must obtain prior authorization from CareCare before having the imaging/radiology services provided. Your non-participating doctor should call CareCore at: 1-866-496-6200 to obtain prior authorization. **IF PRIOR AUTHORIZATION IS NOT OBTAINED, THE CLAIM WILL BE DENIED.**

Additional Information

Attached, please find answers to some frequently asked questions regarding Horizon BCBSNJ's radiology/imaging services program.

If you have further questions concerning this program, please call your Fund office at 908-687-4488.

Very truly yours,

Mary Anne Gerlach
Plan Manager

/encl.

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

Horizon Blue Cross Blue Shield of New Jersey's Radiology/Imaging Services Programs

Frequently Asked Questions

Who is CareCore National?

CareCore National, LLC (CCN) is a nationally recognized, physician-owned, radiology/imaging management service company who has an established reputation for leadership in radiology benefit management. Its physician culture places CCN in a position to offer more effective management services and the ability to understand the professional and practical implications of Advanced Imaging Services (AIS).

What will CCN do for Horizon BCBSNJ?

CCN is working in conjunction with Horizon BCBSNJ to manage the AIS for our members through prior authorization with physicians. CCN helps ensure appropriate radiology/imaging services for our members and provide clinical consultation to our participating providers.

What are the Advanced Imaging Services (AIS)?

The Advanced Imaging Services (AIS) for which prior authorization is required are:
CT, CTA, MRI, MRA, PET and Nuclear Medicine (including Nuclear Cardiology).

Who is responsible for obtaining the prior authorization?

It is the particpating prescribing physicians' (i.e., primary care physicians and specialists) responsibility to contact CCN through the toll-free number for a prior authorization for AIS exams.

Outline of how the Scheduling Process works:

- The Scheduling Line is a service provided by CCN to Horizon BCBSNJ physicians and members to assist in scheduling radiology/imaging procedures for patients.
- CCN will review the requested procedure according to existing criteria. If medicallyappropriate, physicians will receive confirmation of medical necessity.
- CCN will contact the patient by telephone to schedule the procedure at a participating rendering location. The patient will receive a letter from CCN confirming the scheduled appointment.
- When scheduling has been completed, CCN will fax a notice to the physician's office with the PA/MND confirmation and the location where the imaging procedure will be performed.
- CCN will attempt to contact the member for 48 hours after the approval has been given. If the member can not be reached, CCN will issue the authorization to a site located nearest to the member.

Under what circumstances will CCN accept a call from the radiology facility?

CCN will accept calls from the local Blue Cross Blue Shield participating radiology facility for any procedural change to what was authorized (within 2 business days of the performed procedure).
Please Note: Any change of procedure (different from what was authorized) will require the facility to justify the need of that change with CCN.

In addition, CCN should be notified by the site or patient when changing the location where services will be rendered.

How does the physician prior authorization process work?

1. The ordering physician's office must contact CCN utilizing the toll-free number **1-866-496-6200** (Monday through Friday from 7 a.m. to 7 p.m. Eastern time) or via a 24-hour toll-free fax line **1-800-637-5204** or through the Web site: **<www.carecorenational.com>**.
2. CCN will ask for relevant clinical information and history. Examples of required documentation:
   - Completed fax authorization form
   - Clinical office notes
   - Consultation reports
   - Previous diagnostic reports
3. Generally, authorization numbers will be provided at the end of the call (**providing all necessary clinical information has been provided**).

For more information about CareCore National please visit <www.carecorenational.com>.

Services and products may be provided through Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc., each of which is an independent licensee of the Blue Cross and Blue Shield Association.

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

Horizon Blue Cross Blue Shield of New Jersey's Radiology/Imaging Services Programs

Frequently Asked Questions

Fax forms are available on www.carecorenational.com.

What are the turnaround times for prior authorization determinations?

- General requests will be resolved within 48 hours, providing all necessary information has been supplied.
- Medically urgent cases (not life threatening and can wait up to 3 hours) are resolved as soon as possible but no longer than 3 hours.
- Cases involving a medical emergency should proceed to the nearest Emergency Room; pre-certification is not required.

Please note: Medically urgent cases should be called into CCN at 1-866-496-6200.

Prior Authorization does not apply to radiology/imaging services rendered during Emergency Room visits, Observation Unit or Inpatient stays.

What is available for physicians on CCN's Web site?

- **Eligibility Lookup**- advises which members require prior authorization.
- **Authorization Lookup**- shows current status of authorizations (approved, denied, awaiting clinical documentation or currently in review).
- **Authorization requests**- allow the office to initiate the authorization request through the Web site (requires registration).
- **Downloadable forms**- fax forms are available through the Web site.
- **Physician Guidelines**- current evidence based recommendations regarding imaging.

Web address: www.carecorenational.com

What if the physician does not agree with CCN's determination?

We highly recommend the physician contact the CCN Peer to Peer Consultation Line. The physician will be able to discuss the actual case in detail with a CCN Medical Director. In most cases missing clinical information is often clarified once this discussion takes place.

Telephone number: 1-800-918-8924 x11858

How does this apply if the participant uses a non-participating referring physician?

When using a non-participating referring physician, it will be the participant's responsibility to advise the referring doctor that the doctor must obtain prior authorization from CareCore before having the imaging/radiology services provided. The non-participating provider must call CareCore at: 1-866-496-6300 to obtain prior authorization. **If prior authorization is not obtained, the claim will be denied.**

What are the contact numbers for physician prior authorization determinations?

Telephone number: **1-866-496-6200**

Fax number: **1-800-637-5204**

What happens if services are received without prior authorization?

If you visit an Out of Network physician and are referred for radiology/imaging services, it is the member's responsibility to contact CareCore to receive prior authorization prior to services being performed.

It is the prescribing physicians' (i.e., primary care physicians and specialists) responsibility to contact CCN through the toll-free number for a prior authorization for AIS exams when that provider is In Network.

What are CCN's hours of operation?

CCN's clinical staff are available Monday through Friday from 7 a.m. to 7 p.m., ET and with fax availability 24 hours, seven days a week.

For more information about CareCore National please visit <www.carecorenational.com>.

Services and products may be provided through Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc., each of which is an independent licensee of the Blue Cross and Blue Shield Association.

Teamsters Local 641 Welfare Fund
714 Rahway Avenue, 2nd Floor, Union, New Jersey 07083
Telephone: (908) 687-4488
Fax: (908) 687-8368

March 31, 2011

NOTICE ABOUT THE EARLY RETIREE REINSURANCE PROGRAM

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

Very truly yours,

Mary Anne Gerlach
Plan Manager

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TEAMSTERS LOCAL 641 WELFARE PLAN

SUMMARY OF MATERIAL MODIFICATIONS

TO: Plan Participants

FROM: Board Of Trustees

SUBJECT: Patient Protection and Affordable Care Act (PPACA)

DISTRIBUTION DATE: March 31, 2011

EIN: 226220289
PLAN NUMBER: 501

Dear Participant:

This notice contains important information regarding changes to the Teamsters Local 641 Welfare Fund. Please take the time to read this carefully and share it with your family. Keep this notice with your Welfare Plan documents.

The Board of Trustees of the Plan has made the following changes to the Plan, in order to comply with the requirements of the new health reform law formally known as the Patient Protection and Affordable Care Act of 2010.

Benefit Changes Effective March 1, 2011

1. Lifetime Maximum

Current - $100,000, per lifetime, excluding inpatient hospital facility charges.

New Benefit - $100,000, per year, excluding inpatient hospital facility charges. The lifetime maximum is eliminated.

2. Sleep Study

Current - $1,000 per lifetime,

New Benefit – $1,000 per year for the sleep study. Durable medical equipment prescribed for sleep apnea treatment will be paid separately under the Fund's allowance for durable medical equipment. The plan does not pay for replacements, repairs or enhancements of durable medical equipment.

(OVER)

3. Foot Orthotic

Current - Limit one benefit per lifetime.

New Benefit – same as all other durable medical equipment. The plan does not pay for replacements, repairs or enhancements.

4. Inpatient Substance Abuse

Current - Subject to pre-approval, and 100% coinsurance (At plan contracted facilities only) One course of treatment per lifetime up to 30 days.

New Benefit – Subject to pre-approval, and 100% coinsurance (At plan contracted facilities only) One course of treatment per year up to 30 days.

If you have any questions concerning these changes of your Welfare Plan benefits, please contact the Fund Office.

Very truly yours,

Mary Anne Gerlach
Plan Manager
FOR THE BOARD OF TRUSTEES

Teamsters Local 641 Welfare Fund

714 Rahway Avenue, 2nd Floor, Union, New Jersey 07083
Telephone: (908) 687-4488
Fax: (908) 687-8368

March 31, 2011

The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least $750,000.

Your health insurance coverage, offered by Teamsters Local 641 Welfare Fund, does not meet the minimum standards required by the Affordable Care Act described above. Instead, it puts an annual limit of:

$100,000 on major medical benefits

In order to apply the lower limits described above, your health plan requested a waiver of the requirement that coverage for key benefits be at least $750,000 this year. That waiver was granted by the U.S. Department of Health and Human Services based on your health plan's representation that providing $750,000 in coverage for key benefits this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. This waiver is valid for one year.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact the Fund Office.

Very truly yours,

Mary Anne Gerlach
Plan Manager

Teamsters Local 641 Welfare Fund

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IMPORTANT REMINDER ABOUT OUT OF NETWORK BENEFITS

August 22, 2011

To: All Participants of Teamsters Local 641 Welfare Fund with Horizon PPO Benefits
Re: Out of Network Benefits

Dear Participant:

The Fund office has recently been faced with several issues related to out of network benefits. The Summary Plan Description (SPD) provides information as to what services are, and are not, covered on an out of network basis and the payment schedule for those benefits. We urge you to familiarize yourself with these benefits and exclusions.

Among the benefit misunderstandings that have been encountered recently are claims submitted by providers for the following **NON-COVERED** services:

1) Inpatient facility fees at out of network hospitals (including mental health, substance abuse and extended care facilities);
2) Out of network hospital facility charges for outpatient surgery;
3) Out of network ambulatory surgery center facility charges;
4) Durable medical equipment purchases from out of network providers;
5) Out of network hospital facility charges for diagnostic x-ray and laboratory services;
6) Out of network dialysis or radiation therapy;
7) Out of network home health care;
8) Out of network health wellness services (this includes routine mammography, routine OB/GYN exams for female participants and female spouses, routine Pap Smear for female participants and female spouses, prostate cancer screenings, blood occult screenings, and well child immunizations).

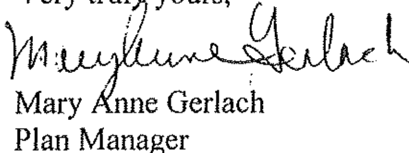
(OVER)

For those services that are covered on an out of network basis, the plan pays 70% of reasonable and customary allowances after the patient has reached his or her $300 annual deductible. It is important to remember that even though you may not have a choice of provider (for example – on an emergency basis), the plan can only pay an out of network claim as provided by the terms outlined in the Summary Plan Description. If the provider's fee is above reasonable and customary, we suggest that you bring that fact to his or her attention.

In several cases we have discovered that medical providers rely solely on Horizon Blue Cross/Blue Shield for benefits payable under our plan. Horizon representatives provide this information based on an outline of our plan's benefits that the plan is required to provide to Horizon. We have repeatedly requested that Horizon refer all calls regarding benefit information to the Fund office because **THE TRUSTEES HAVE NOT AUTHORIZED ANY HORIZON REPRESENTATIVE TO VERIFY BENEFITS PAYABLE BY OUR PLAN FOR ANY PARTICIPANT OR DEPENDENT. Therefore, we urge you to contact the Fund office yourself to verify that the provider has contacted the Fund office for benefit information. Do not rely on any information received from your provider based on an oral or written communication from Horizon. The plan cannot be held responsible for any oral or written miscommunication between a provider and Horizon's representatives.**

As always, the staff at Teamsters Local 641 Welfare Fund is eager to help the participants and dependents with any questions or concerns you may have regarding your benefits. We want to make sure that you do not incur unexpected out of pocket costs based on information received from any other source.

Very truly yours,



Mary Anne Gerlach
Plan Manager

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