SUMMARY OF MATERIAL MODIFICATIONS
AND
NOTICE TO PARTICIPANTS

NEW YORK STATE TEAMSTERS COUNCIL
HEALTH & HOSPITAL FUND

(Plan No.: 501; I.D. No.: 15-0551885)

July 30, 2009

Dear Participant:

This letter contains important information regarding changes adopted by the Board of Trustees of the New York State Teamsters Council Health and Hospital Fund (the "Fund"). As explained below, some of he changes will be effective October 1, 2009 and others will be effective January 1, 2010. Please read this letter carefully and keep it with your copy of the Summary Plan Description for the Fund.

Effective October 1, 2009, the following changes will occur:

CHANGES IN THE SUPREME (INDEMNITY) PLAN

- **A $10 co-pay will be required for the following physician services (previously required no co-pay).**

- Diagnostic Office visits
- Mental Health Care visits
- Office Surgery
- In Hospital Physician visits
- Well Child Visits & Immunizations
- Diagnostic Eye Exams
- Diagnostic GYN visit
- Allergy Serum
- Inpatient Consultations
- Urgent Care Center
- Physical / Occupational Therapy
- Pulmonary / Cardiac Rehabilitation Therapy
- Office / Outpatient Consultations
- Chemical Dependency visits
- Second Surgical / Medical Opinion
- Routine Physical Exams
- Adult Immunizations
- Routine Eye Exams (child up to age 19)
- Allergy Testing and Treatment
- Chiropractic Care
- Treatment of Diabetes (non pharmacy)
- Emergency Room Physician visit
- Speech/Respiratory Therapy

- **A $100 co-pay will be required for Emergency Room visits that do not result in an inpatient hospital admission (previously required no co-pay).**

- **New member ID cards will be issued by Excellus BlueCross BlueShield based upon the approved conversion to a new processing platform. Excellus expects to mail the cards during the middle of September with all delivered by September 26, 2009.**

CHANGES IN THE SELECT (PPO) PLAN

- **A $20 co-pay will be required for the following physician services and diagnostic testing services (previously required a $15 co-pay).**

- Diagnostic Office visits
- Mental Health Care visits
- Office Surgery
- In Hospital Physician visits
- Well Child Visits & Immunizations
- Diagnostic Eye Exams
- Diagnostic GYN visits
- Allergy Serum
- Inpatient Consultations
- Urgent Care Center
- Mammogram and Pap Smear
- Physical / Occupational Therapy
- Home Health Care
- Newborn Care
- Laboratory / Pathology
- Pulmonary / Cardiac Rehabilitation Therapy
- Office / Outpatient Consultations
- Chemical Dependency visits
- Second Surgical / Medical Opinion
- Routine Physical Exams
- Adult Immunizations
- Routine Eye Exams (child up to age 19)
- Allergy Testing & Treatment
- Chiropractic care
- Treatment of Diabetes (non pharmacy)
- Emergency Room Physician visit
- Bone Density Testing
- Kidney Dialysis
- Prostate Cancer Screenings -
- Radiation and Chemo Therapy
- Speech/Respiratory Therapy

- **A $30 co-pay will be required for the following diagnostic services (previously required a $15 co-pay).**

- Outpatient Surgery / Surgicenters
- Diagnostic X-Rays & Imaging
- Pre Admission Testing
- Diagnostic Machine Tests

- **A $100 co-pay will be required for Emergency Room visits that do not result in an inpatient hospital admission (previously required a $50 co-pay).**

Effective January 1, 2010, the following changes will occur:

CHANGES IN THE SELECT (PPO) PLAN

Coinsurance: Covered in-network services currently reimbursed by the Fund at 100% of the allowable amount will be reimbursed at 95%, up to an annual out of pocket maximum of $1,000 per individual and $3,000 per family. Once the annual out of pocket maximum is reached, all covered services will be reimbursed at 100% of the allowable amount.

- The following covered in-network services are impacted :

- Inpatient Hospital Services
- Acute Inpatient Mental Health Care
- Acute Inpatient Chemical Dependency Care
- Skilled Nursing Facility
- Durable Medical Equipment / Medical Supplies / Prosthetics
- Observation Stays
- Detoxification
- Anesthesia
- Maternity Care / Birthing Centers

GENERAL ELIGIBILITY CHANGES THAT AFFECT ALL PLANS

- NO "OPT OUT" PROVISION FOR SPOUSE'S COVERAGE.

  Currently, if your spouse is eligible to be covered under his/her employer's benefit plan as an employee and is eligible for such group coverage at no cost or a cost of 2% or less of your spouse's wage, or receives a monetary payment for declining that coverage, and your spouse does not enroll in such coverage (opts out), your spouse may not be covered as an eligible dependent under this Plan.

  Effective January 1, 2010, if your spouse is eligible to be covered under a separate group medical plan as an employee and such group coverage is available at **no cost or a cost of 5% or less of the spouse's wages,** or receives a monetary payment for declining that coverage, the spouse may ***not*** "opt out" of that coverage.

  The Fund Office will supply the form that needs to be completed by your spouse's employer to verify the cost and coverage available.

  All spouses will need to re-qualify for this provision annually beginning in 2010. Re-qualification will begin during the fourth quarter of each year.

If you have any questions, please contact the Fund Office at 315.455.9790 or 1.877.698.3863 and select Option 1.

Sincerely,

BOARD OF TRUSTEES
NEW YORK STATE TEAMSTERS COUNCIL
HEALTH & HOSPITAL FUND