Local 830

THE REPORTER

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Special Healthcare Edition 2010

Seasons Greetings

From the Officers, Agents & Staff of Local 830

Danny Grace, Chuck White, Glenn Fulcher, Jack O'Rourke, Jim Brown, Tony Mastrome, Ed "Obie" O'Brien, Van Artis, Billy Peal, Susanne Deluisi, Rose Mary Crescitelli, Kristina Crawford, Nick DeIeso, Sam Kenish, Lee Togneri, Aggie Breen, Joanne Creedon, Donna DiFrancesco, Claire Dodd, Shirley Dustman, Diana Foschini, Priscilla Gray, Mary Joniec, Cathy Knasiak, Eleanor Riley, Jennifer Schmeltzer and Lynn Valenti

Happy & Healthy New Year to all our Members and their Families!

CONGRATULATIONS DANNY DOGGS ON YOUR RETIREMENT!

We wish you the BEST!

Danny Santosusso has decided to retire after 42 years in the Teamsters labor movement. His motto as an officer of Local 830 was "always put the members first." His decision to retire was based on spending more time with his wife Cindy and their grandchildren.

Dan Grace, Secretary Treasurer stated that "Danny will be missed, his experience was invaluable and he was always there when you needed him."

Replacing Danny on the Executive Board will be Ed "Obie" O'Brien. Obie has 25 years in Local 830 and currently is our Chief Shop Steward at Origlio Beverage.

The Executive Board wished Danny much happiness on his retirement and wishes Obie much success in his new appointment.

Secretary Treasurer's REPORT

...Dan Grace

Being a union official is easily one of the most thankless jobs a person could have. For me, this has never been more evident than now. When I took this job in 2001 I vowed that if I failed, it would have nothing to do with the amount of effort I gave or the sincerity with which I would represent the interests of our members. I'm very proud to say that I have not broken this promise to myself. Yet I am increasingly led to feel that even my best efforts will never be good enough for some; that there is an undercurrent of distrust. There is no better example of this than the reaction I have seen from certain members concerning the changes we have made to our health plans.

The healthcare crisis has been a major focus of attention in this country for decades. It was the top issue in the last presidential campaign and remains the top issue of this administration. Legislation signed into law this past March is already costing public officials their jobs. This crisis has reached a stage that is very likely to have catastrophic consequences in the near future.

As co-chairman of the Health & Welfare Fund I have done everything in my power to protect the interests of our members. We have taken advantage of some of the most talented professionals in the labor environment to help us manage our plans, including our Fund Administrator. With their guidance we have somehow miraculously managed to avoid making major changes in our medical and prescription drug plans for 12 years, including the entire time I have sat as a Trustee on this Fund. I have been extremely proud of this accomplishment and have felt in the past that our members appreciated these efforts.

Now, twelve years later, exhausting every possible strategy for controlling costs, we are caused to make the very difficult decision to change our plan designs and to implement health management initiatives and what is the reaction of our members to this? Is it, "I know you are doing your very best in an impossible environment?" Is it, "I have trusted you in the past to look out for my best interests and have no reason to feel any differently now?" NO! What I'm hearing is, "You screwed me," "You deceived me," "Why did you ALLOW my benefits to be changed?" "Who do you think you are asking me to do a better job managing my health?"

For these members I have the following NEWSFLASH:

DANNY GRACE DOES NOT HAVE THE SECRET SOLUTION TO OUR NATION'S HEALTHCARE CRISIS… DANNY GRACE HAS NO REASON TO SCREW OR DECEIVE OUR MEMBERS IF HIS DESIRE IS TO CONTINUE TO LEAD THIS GREAT UNION…DANNY GRACE IS AFFECTED BY THESE HEALTHCARE CHANGES IN EXACTLY THE SAME WAY AS EVERYONE ELSE… DANNY GRACE DOES NOT LIKE HAVING TO PAY MORE FOR HEALTHCARE SERVICES OR TO EXPEND MORE EFFORT TO MANAGE HIS HEALTH – BUT HE UNDERSTANDS WHY THIS IS NECESSARY.

I continue to give my very best effort to representing the interests of our members, as always. The changes made to our healthcare programs were absolutely necessary. They were unavoidable. Yes, the Fund did take an aggressive position regarding health management. However, this is the kind of forward thinking that has helped us manage the plans so well all along. The fact that other unions in this area have not been as aggressive is not an indication that these things are not necessary. In fact, many are contemplating similar changes as we speak. It is simply that we have an excellent group of professionals whose approach has always been to think ahead; to be proactive. Given the critical environment in which we find ourselves and knowing what is at stake, I am grateful to have such people working on our behalf, even if the recommendations received from them are difficult to swallow.

As we enter this holiday season and await another New Year I ask all of you to count your blessings, to commit yourselves to working together and with all of your officers and agents at Teamsters Local Union No. 830 in the New Year as we all struggle with the many challenges before us. It is only in unity that we find strength.

May God bless you and your family during this holiday season!

Ed "Obie" O'Brien takes on Trustee appointment

CONTRACT NEWS

Banko Beverage Allentown

Our members voted unanimously to accept a one year extension on their current Collective Bargaining Agreement. All Employees shall receive wage increases, all other terms and conditions shall remain in full force and unchanged. The negotiating committee included Glenn Fulcher, from Local 830 and Shop Stewards—Ed Sabol and Jan Schuster.

Holiday Inn

The Employees voted yes to accept a final offer from the hotel. The current Collective Bargaining Agreement doesn't expire until June 2011. The Hotel and Union agreed to meet each year of the agreement to review the financial condition of the Hotel and to negotiate wage and R.S.P. contributions. The Agreement included wage increases, increased money for additional room and increases in R.S.P. The committee included Glenn Fulcher and Jim Brown from Local 830 and Shop Stewards Renee Carter.

Canada Dry

Our members employed at Canada Dry voted by a 3-1 margin to accept a two year extension on their current Agreement which was to expire on July 31, 2010. All conditions in the current Agreement shall remain in full force, effect and unchanged. Our members shall receive wage increases each year retro-active to April 1, 2010. The negotiating committee included Dan Grace, Glenn Fulcher and Jim Brown from Local 830 and Shop Stewards -Whitney Price, Ed Mezzanotee and Joe Ashman.

Allentown Beverage

Our members voted unanimously to accept a four year agreement. Increase in wages each year, Increase in pension/RSP in years 3 & 4, increase in sickness/accident insurance and maintained all health benefits. The committee included Local 830 Glenn Fulcher and Shop Steward Jeff Lutz.

Borough of Hatboro

Our members employed at the Borough of Hatboro voted unanimously to accept a 5 year agreement. The agreement will raise wages each year of the agreement, maintain all benefits additional gains and no concessions. The committee consisted of Glenn Fulcher from Local 830 and Shop Stewards Charles Young and Matt Lynch from Hatboro.

Borough of Hatfield

Our members ratified a new five year agreement unanimously. Wage increases each year, RSP increases each year and maintaining current health benefits. Committee included Glenn Fulcher from Local 830 and Shop Steward , Ed Polaneczky.

Scholarship News

If you have a son or daughter who is a senior in high school and are interested in applying for the IBT Hoffa Scholarship then please call the union office and ask for an application. All applications for the Hoffa Scholarship must be returned to the union office no later than two weeks prior to March 31, 2011. Students wishing to be considered for the Teamsters Local 830 Scholarship Awards are encouraged to act quickly because all application material must be postmarked or received by March 1, 2011.

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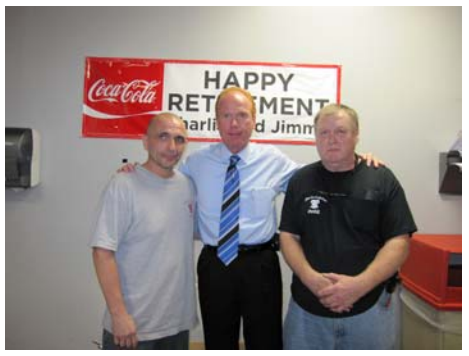
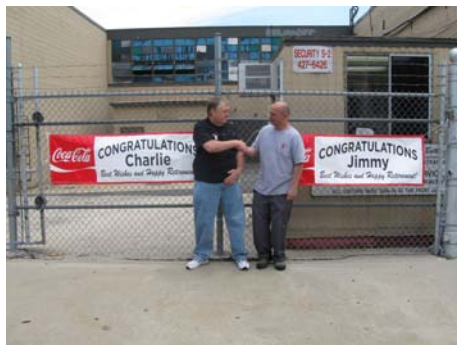
CONGRATULATIONS TO CHARLIE SCHOFFLER AND JIMMY MILES OF PHILLY COKE ON THEIR RETIREMENT!



Left to Right
Jimmy Miles, Glenn Fulcher and Charles Schoffler



SHOP STEWARDS CORNER

NEW SHOP STEWARDS

Thomas Lyons—Pepsi Blvd.
Andrew Mainhart—Allentown Beverage
Shelia Crawley—Jerith
Shaka Johnson—Pepsi West Chester
Matthew Lynch—Borough of Hatboro
Brent Since—Borough of Hatboro
Guy Helder—Coke
Jason Langdon—Pepsi Pennsauken
Joe Cilio—Philly Coke

Answers to Your Healthcare Questions

As you might imagine, we have received a significant number of questions from our members about the changes to our health plans occurring this past September. Knowing that many folks have not engaged us directly, we decided it might be helpful to share the questions received along with our responses in hopes that this will provide a better understanding of the process involved and rationale for making such changes. If you have questions that have not been addressed here, we strongly encourage you to contact us at the Fund Office.

WHY DID MY HEALTH COVERAGE CHANGE?

To answer this question one only need pick up a newspaper or turn on the television. Healthcare spending is a national crisis. In 2008 health expenditures reached $2.3 trillion which translates to $7,681 per person or 16.2% of the country's gross domestic product. Some experts forecast this spending to top $16 trillion by the year 2030. And despite the best intentions of our president, healthcare reform does not appear to offer any real hope of abating this crisis.

The Board of Trustees of the Health & Welfare Fund, assisted by the Fund Administrator and other professional advisors, has done its very best to avoid making changes to your coverage in the midst of this crisis and has been very successful in doing so for the past twelve years. This success has resulted from very aggressive negotiation with our health insurers, affiliation with the Delaware Valley Health Care Coalition, a consortium of labor health funds that negotiates volume discounts for a variety of services, leveraging market competition and strategies designed to maximize value from within existing plans.

Unfortunately, a number of factors, including the unprecedented downturn in our nation's economy, have conspired to create the most challenging healthcare environment yet. It has become commonplace to see medical insurance rate increases in the range of 20-40% locally. The Fund's increase in 2009 exceeded 20% but was reduced to just below 14% due to previously negotiated rate relief. A projection of our 2010 renewal showed an increase of 23%. In addition, our prescription drug program was projecting an increase of 14.65%. The Trustees of the Fund had no choice but to take action to preserve this very valuable coverage.

It is important to note that even with the changes made to your plans, the Fund is estimated to spend approximately $25 million on healthcare in the fiscal year that begins 9/1/10. This equates to approximately $12,250 per year or $1,020 per month on average for each covered member.

HOW CAN MY HEALTH COVERAGE BE CHANGED OUTSIDE OF COLLECTIVE BARGAINING?

The Board of Trustees of the Health & Welfare Fund has exclusive authority and responsibility to determine coverage provided through the Fund. The Board has a fiduciary duty to discharge its responsibilities in the best interests of plan participants and beneficiaries and has exercised its authority on numerous occasions in the past. For instance, the Board changed the medical and prescription drug coverage offered to participants in 1998. In 2004, 2006 and 2008 the Board changed provisions of your prescription drug plan. Similarly, the Pension Fund Trustees made improvements to the pension multiplier twice during the past decade. All of these changes were implemented outside of bargaining and were deemed to be in the best interests of participants and beneficiaries.

WHO ARE THE BOARD OF TRUSTEES AND WHAT IS THEIR RESPONSIBILITY IN MANAGING THE HEALTH & WELFARE FUND?

The Board consists of equal representatives from labor and management. These individuals have a legal responsibility to make sure the benefit plans offered through the Trust are managed prudently and in the best interests of plan participants and beneficiaries. All monies contributed to the Trust must remain with the Trust and be used for the exclusive benefit of participants. By law, contributions made to the Trust cannot revert back to the employers or the union.

DOES THE BOARD OF TRUSTEES EMPLOY ASSISTANCE IN DISCHARGING ITS DUTIES TO THE TRUST?

Yes. In discharging its duties to the trust the Board relies on expertise and recommendations from various paid professionals including lawyers, actuaries, accountants, investment managers, plan administrators, benefits consultants, etc.

WHY WOULD THE UNION TRUSTEES ALLOW CHANGES TO OUR HEALTH COVERAGE?

As explained above, ALL of the Trustees of the various benefit funds, including your union representatives, are charged with the responsibility of acting in the best interests of plan participants and beneficiaries. To do otherwise would potentially be considered a breach of fiduciary duty and expose them to severe penalties. In the case of the recent changes to your health coverage, the Trustees had no realistic option but to follow the recommendations of plan professionals who advised that the Fund would be placed in a deficit spending situation (not enough money coming in to fund the promised benefits) if they did not authorize coverage changes. In addition, it was the recommendation of plan professionals that a more aggressive strategy for management of member's health issues be employed in an effort to mitigate the extent of future anticipated increases in the cost of medical insurance. As you can imagine, the very last thing your union representatives wanted to do was authorize a reduction in coverage and impose strict health guidelines on their members who are plan participants. However, the circumstances dictated this action in order to avoid a situation where the Fund did not have enough money to pay promised benefits.

HOW DID THE FUND DETERMINE THE EXTENT OF CHANGES NEEDED?

There were a number of considerations in determining the extent to which modifications were needed. First was the immediate financial need. Many of the Fund's participants are covered under collective bargaining agreements that limit the amount of contribution increases funded by the employer and employees. In most cases this is expressed as a percentage of the prior year's contribution and is typically 12%. Clearly, if we have premium increases in excess of 12% this creates a funding deficiency since the premium charged would be greater than the contribution received. However, modifying coverage only to the extent necessary to secure funding for the current year is a short-sighted approach. Accordingly, the changes reflect many months of discussion with our insurer, clinical advisors and other health partners. They are intended to both reduce current costs and to positively affect member utilization patterns, in an effort to mitigate future cost increases.

Some members have argued that we should only have made changes that would have brought current cost down to their negotiated cap. Others whose collective bargaining agreements do not specify a cap have argued that we should have made no changes to the coverage and passed the entire increase onto their employers. Neither approach makes sense from a long term survival perspective. As indicated, focusing only on current financial need ignores the long term consequences of flawed utilization patterns. And, those who say "don't touch the coverage," ignore both this reality as well as the fact that if their employers are caused to withstand a 20+% rate increase, this money will have to come from somewhere. Perhaps it will mean cutting out overtime or maybe lay-offs. Maybe the employer will decide that it can no longer fund healthcare for its employees. In the worst case, maybe the employer will be forced to cease operations altogether. Every action has a consequence.

Our perspective has always been that every dollar of healthcare cost belongs to you, whether it is the contribution made by your employer which was negotiated as part of your total compensation package, any portion of the premium paid directly by you and any out-of-pocket cost incurred from within the plans themselves. When viewing healthcare cost from this perspective, there is no confusion as to who is benefiting from the changes we propose. Our decisions are exclusively made with you in mind. In our experienced opinion, the strategy adopted produces the best possible value for all members utilizing the plan.

WHY ARE WE CAUSED TO PARTICIPATE IN THE FUND'S HEALTH MANAGEMENT PROGRAM?

The short answer is that our health is the only thing in this very complex health care system that we can actually control. It has long been established that if we do a better job at managing our health, the amount of medical care required will be significantly reduced. Those with chronic diseases like diabetes and cardiovascular disease typically account for about 80% of health care spending. If we can help our members do a good job managing these diseases, it stands to reason that our future spending will be less. In addition, it is important to

help those people whose risk of developing chronic disease is greatest, like smokers and those who are clinically obese, to make lifestyle changes in an effort to avoid such disease, thereby stopping the chain of increased spending. If successful, our members will both enjoy improved quality of life and also lower health care cost. Wouldn't it be great to spend less on health care so that we can put more in our pockets and into other benefits like pension, for instance?

WHY DOES MY INDIVIDUAL BEHAVIOR MATTER?

The answer lies in the nature of group health insurance. In a group health insurance environment, all individuals' claims are added together to determine the total claims cost of the group, which, in turn, determines the total premium cost in the following period. Those doing a good job at managing their health will produce less claims over time on average while those not doing such a good job will produce more claims. Since the premium paid is an average of all claims, the well managed members wind up paying for the poor behavior of others. Not only is this unfair but if we do not do something about it immediately, we may very well not be able to afford meaningful health insurance in the near future.

Rating individuals on the basis of risk is not a new concept in insurance. Life and auto insurance companies have been using this process for many years. For instance, if you are a smoker or have a disease that could potentially increase your chances of premature death, you pay more for life insurance because you present a greater risk to the insurance company. Those who are deemed healthy by the insurer pay less. This means that you pay your own freight. The decisions you make affect you directly and are not borne by others around you. In this extremely challenging environment, it has become necessary for health insurance plans to adopt this same strategy. However, instead of providing individual rating, we will be assessing higher levels of cost sharing to those who choose to do a poor job at managing their health and thus pose additional risk to the group. In effect, these individuals will be caused to pay their own freight and not burden others around them who are trying to do the right things.

WHAT HEALTH ISSUES ARE BEING ADDRESSED IN THE PROGRAM?

The two most important health concerns in our population today are smoking and obesity. Both of these things lead to a number of chronic diseases and increased insurance costs. Therefore, smokers in our population are being asked to participate in a smoking cessation program. The counseling for this program is provided free of charge and any prescribed medications (including over-the-counter drugs) are covered under our prescription drug program at the standard copay level. It is fully recognized that for many smokers it will take multiple tries to quit. Therefore, smokers who are not successful at quitting will not be asked to pay higher deductibles. We simply ask that they participate in smoking cessation programs as they are periodically offered in hopes that at some point they will win the battle and free themselves from this deadly addiction.

About one third of our nation's population is clinically obese and our own population is no different. Of approximately [number] of adult members and spouses covered by our plan, approximately [number] fall into this category. Our goal with these folks is to help them do a better job at managing their weight. We are not requiring that they achieve a specific weight goal but simply that they work with us in hopes that they will develop better eating and exercise habits which will eventually lead them in this direction. Participation in this program will continue until the targeted individual's BMI is measured at below the national standard for obesity, presently 30.

Those choosing to ignore the protocols of these programs will be placed in a higher deductible plan next September since failure to manage these health issues creates greater risk for the group.

WHICH CHRONIC DISEASES ARE TARGETED BY THE PROGRAM?

The program addresses four chronic diseases: Cardiovascular Disease (including congestive heart failure), Type II Diabetes, Hypertension and High Cholesterol. Again, there is very good evidence to suggest that proper management of these diseases will lead to better health outcomes and lower cost. As indicated, it is chronic disease that accounts for the majority of our healthcare spending. Most of the protocols required in the program are common sense things that any prudent person with such diseases should already be doing.

Those choosing to ignore the protocols for these diseases will be placed in a higher deductible plan next September since failure to manage these diseases creates greater risk for the group.

WHAT PREVENTIVE SCREENINGS ARE BEING REQUIRED BY THE PROGRAM?

Colon and breast cancer are both diseases whose outcomes benefit greatly by early detection. Astoundingly, only about 20% of our population eligible for these screenings have taken advantage of them. Accordingly, we are requiring that everyone meet the national standard for screenings of these diseases.

In the case of colon cancer this typically means once every 10 years after age 50. If issues are detected, the frequency may be shortened to every 5 years. As long as the test is classified as preventive screening by your physician, no plan copays or deductibles will apply. (If you receive a bill, please advise the Fund Office immediately.) Also, many folks report that the most difficult part of undergoing this screening is the bowel preparation. Individuals tolerate certain preparations better than others. For instance, preparations come in a number of liquid forms but also are available in pill form which certain people prefer. To make this screening as convenient as possible, we are now covering all bowel preparations under our prescription drug program at the standard copay. If you choose a pill preparation, the pharmacist will need to call the Fund Office for a prior authorization. Lastly, you need to be aware that some physicians perform this procedure in their offices. Not only is this very convenient but also is a much lower costing event. Therefore, we encourage you to consider this approach. The Fund Office can direct you to physicians who perform this screening in their offices.

Breast cancer screening is required every year or two after age 50 under the national standard, which is what our program is using to determine compliance. However, you should be aware that our insurer, Independence Blue Cross, continues to use the American Cancer Society's recommendation that screenings begin at age 40 and therefore will cover them beginning at that time. You are free to begin screening at age 40 but we will require it beginning at 50. These screenings are covered in full under our insurance contract.

Those choosing to ignore the screening requirements will be placed in a higher deductible plan next September since failure to screen creates greater risk for the group.

IF BENEFIT UTILIZATION IS A CONCERN, WON'T ALL OF THE TESTING REQUIRED UNDER THE FUND'S HEALTH MANAGEMENT PROGRAM INCREASE, NOT LOWER, COST?

In the short term, getting folks to follow prevention, wellness and disease management guidelines will indeed increase costs. However, by following these protocols, we will be averting the catastrophic costs often associated with those who do not do a good job at managing their health, which substantially outweigh the cost of these management activities and is our primary focus.

WHO IS COORDINATING THE FUND'S HEALTH MANAGEMENT PROGRAM?

In an effort to make this program as convenient as possible for our members, all activities are being coordinated through the Fund Office. Our staff has access to all information needed to assist you in complying with the protocols whether it is connecting you with a health advocate, health coach or case manager, locating providers and a host of other things. Please use the Fund Office as your gateway to all resources connected to the Fund's health management program in addition to our traditional activities such as claims issues, plan interpretation, billing, eligibility and other matters. Call 215-969-1012 or 800-782-5379 or write to us at my-health@team830.org.

Much of the clinical support for this program is being provided by our partner, Health Advocate. When calling the Fund Office we will often recommend that your call be transferred to one of their health advocates, health coaches or case managers. Once you have established a relationship with one of these folks, you can feel free to contact them directly.

WHAT DOES IT MEAN IF I RECEIVE A "TO-DO" LIST FROM THE FUND OFFICE?

If you receive a To-Do list it means you have been identified with one of the health, disease management or preventive health issues discussed above. The very first thing you should do after receiving a To-Do list is to contact the Fund Office to discuss the list and ask any questions you may have about the list, why you have been identified, any discrepancies you may suspect, etc.

IS IT POSSIBLE THAT DISCREPANCIES COULD EXIST IN IDENTIFYING CERTAIN HEALTH ISSUES THAT PROMPT RECEIPT OF A "TO-DO" LIST?

The short answer is "yes." As with any undertaking of this kind, information is only as good as the data in our possession. Much of this

program is built on medical and drug claims data, in addition to information you have reported to us. Other data sources will be included in the future that will enhance the program. Sometimes data is incomplete or misinterpreted by the system which can lead to potential errors. These things will be rooted out as we move forward. However our present tact is to include as many folks as the data provides under the theory that it would be better to include too many rather than exclude anyone. If you feel that you have been incorrectly identified for inclusion in the program, please immediately contact the Fund Office. We will investigate into your concern and advise you of our findings.

Another issue that has been identified in the early stages of the program is that primary care physicians (family doctors) and their contact information referenced on the To-Do lists have been sometimes inaccurate. We are working on this issue and hope to have resolution in advance of mailing your updated (quarterly) list. However, in all cases our goal is that you use your primary care physician for assistance in meeting any applicable protocol. In some cases, you will be able to call your doctor for a prescription to have blood work or other testing completed. However, more often than not you will need to see your primary care physician to obtain written orders for tests required under the program.

HOW DID THE FUND GET MY INFORMATION AND ARE THEY FOLLOWING FEDERAL PRIVACY LAWS IN HANDLING THIS INFORMATION (HIPAA)?

Much of the information used to manage this program comes from medical and prescription drug claims data. As the Plan Sponsor, federal privacy law permits us to use this data to carry out the purposes of the plan and we are bound to treat this data in a confidential manner. Our health partners, like Health Advocate, are similarly bound through contract with the Fund.

HOW DO YOU DETERMINE WHETHER SOMEONE IS OVERWEIGHT OR OBESE AND IS IT POSSIBLE THAT THIS DETERMINATION COULD BE INACCURATE?

The national standard for determining this is called the Body Mass Index, or BMI. By plugging in your weight and height, a number is assigned that determines whether you are overweight or obese according to the national standard. Those of us with BMIs of 25 or more are considered overweight. If BMI reaches 30 or more, we are considered clinically obese. It is our experience that many folks question the validity of this index. However, it is the only measure we have and feel it is better to over-identify rather than the reverse. Certain muscular individuals can get incorrect readings using this index since muscle weighs more than fat. If you fall into this category, please contact the Fund Office to discuss.

MY "TO-DO" LIST INDICATES THAT I NEED CERTAIN TESTS THAT HAVE JUST BEEN COMPLETED. WHAT SHOULD I DO?

Unfortunately, due to the timing of claims data, we may not know if certain tests have been performed within a month or two of the issuance of your To-Do list. However, if you know that you have complied with a particular item that appears on your list, simply ignore it. The next time your list is generated, this item should appear with a checkmark indicating compliance. We are working with our providers to reduce this claims lag. However, there is always a chance the data will not reflect things you have done just prior to issuance.

WHAT IF I AM ALREADY DOING SOME OF THE THINGS ON MY "TO-DO" LIST?

Your To-Do list will ultimately reflect that you have complied with the required item by showing a check mark next to that item. As the plan year progresses, we will let you know if you still need to complete any items on your list. We have no intention of waiting until the last minute to notify you. Likewise, if you already have doctor appointments set up or testing scheduled, we suggest that you let these things follow their normal course. In other words, do not change your scheduling simply because you received a To-Do list with certain items on it now. Remember, you generally have until the end of the plan year (8/31/11) to comply.

MY "TO-DO" LIST SAYS THAT I NEED TO HAVE A TEST PERFORMED IN A PARTICULAR MONTH. WHAT IF THERE IS NOT ENOUGH TIME?

The purpose in displaying a specific timeframe for certain testing has to do with making sure you are eligible for insurance coverage. In reality, the month shown on your To-Do list represents the earliest time in which the test will be covered by insurance. We are working with our partners to produce better messaging around these things and apologize for any confusion you may have experienced. The primary question we were asked is whether you needed to get your colonoscopy done in November. While we think it is a good idea to get this screening done as soon as possible, you will be considered compliant as long as you get it done within the plan year, i.e., by August 31, 2011.

I WORK A LOT OF HOURS. HOW AM I GOING TO HAVE THE TIME TO COMPLY WITH ALL THE ITEMS ON MY "TO-DO" LIST?

In developing this program we were acutely aware of our members' time constraints and have done everything possible to limit the burden placed on our members who have been identified with certain health issues. Please consider the following:

- Preventive colonoscopy is only required every ten years (five with certain findings).
- Preventive mammography is only required every one to two years.
- Typical blood work is only required once per year to be compliant and if you have more than one test to complete; these can typically be done in a single visit. The exception is the HbA1C test which is required twice per year for diabetics.
- Primary doctor visits are only required once or twice a year depending on your health condition. If you have multiple health issues, these can be addressed at one time.
- **Listening to concerns expressed by our members and under the guidance of our clinical advisors, we have recently decided to waive certain requirements around weight management with the intention of lessening the burden perceived by our members. Nutritional counseling visits and participation in a diabetes education program will still be available but not required for compliance. Likewise, participation in a management program like Weight Watchers will not be required. All weight management issues will be addressed by our health coaches.**
- Interaction with a health coach or case manager is typically required every six months and this is accomplished by telephone. More frequent interaction is available and encouaged.

All in all, we are confident most members will discover that compliance will involve a much smaller time commitment than appears on the surface.

WITH THE CHANGES IN CO-PAY AND DEDUCTIBLE, HOW CAN I AFFORD TO COMPLY WITH THE HEALTH MANAGEMENT PROTOCOLS?

Again, in developing this program we were very aware of the potential cost burden placed on our members who would be asked to comply with the health management protocols. Consistent with this concern, please consider the following:

- As long as colonoscopy is coded as a preventive screening by your physician, you will not incur any copay or deductible under your medical plan. (If you receive a bill, please advise the Fund Office immediately.) In addition, by covering all bowel preparations under your prescription drug program, the extent of your out-of-pocket cost is limited to your standard copay.
- Mammography has long been covered at 100% under your medical plan.
- All required physician visits are for primary care physicians whose copay is either $15 or $20 depending on your medical plan.
- All preventive blood work is covered without copay or deductible under your medical plan.
- Up to six nutritional counseling sessions per year are covered in full under your medical plan. Although these are no longer required, please feel free to take advantage of this benefit.
- All health advocacy, health coaching and case management interactions are covered in full through the Fund's contract with Health Advocate.
- Smoking cessation counseling is covered in full through the Fund's contract with Health Advocate. Any needed medications are covered under your pharmacy benefit at the standard copay levels.
- Weight management counseling is covered in full through the Fund's contract with Health Advocate. If you should decide that participation in a weight management program such as Weight Watchers or a hospital run program is appropriate, a portion of any related cost is reimbursable under your medical plan. Please contact the Fund Office for details.

WHY AM I PENALIZED FOR NOT COMPLYING WITH THE

HEALTH PROTOCOLS?

No one is being penalized for non-compliance with the Fund's health management protocols. As explained above, those who choose not to comply expose the group to greater risk which is unfair to those trying to manage their health and keep insurance costs down. The higher deductible surcharge is a way of having such folks "pay their own freight" so that no one else is "penalized" by their behavior. Our goal at the Fund Office is to do everything possible to help all of our affected members comply with the protocols and NOT be placed in a higher deductible plan. We took this approach when requesting the medical insurance enrollment form and obtained virtually 100% compliance. We hope that you will work with us to achieve this goal relative to the health management protocols.

Some members have suggested that this is akin to socialism. If by socialism they mean a recognition that we are all in this health care thing together and need to recognize that our individual behavior affects others around us, then perhaps they are right. If your health choices only affected you personally, then no one would care about the choices you make. Of course, poor choices would likely mean that you would no longer be able to afford health insurance in a much quicker timeframe than is the case in a group health insurance environment where health conscious people are effectively subsidizing your poor health choices. Our goal is to preserve a meaningful level of health insurance coverage for all our members for a long as possible.

WHAT HAPPENS TO ALL THE SAVINGS THE FUND GETS IF I AM FORCED TO MOVE INTO A HIGHER DEDUCTIBLE PLAN?

First, it is our hope that all of our members will work with us to achieve compliance with the Fund's health management protocols. For the relatively few who refuse, the impact of any savings in premium will be minimal. However, any savings will effectively be used to offset cost of those who are managing their health in a responsible manner. We have heard some members suggest that proceeds of the "penalty" will go into the pockets of their union representatives. This is complete and utter nonsense. Aside from the many logical reasons why such a thing would not happen, as previously explained, federal law prohibits the reversion of any plan assets to contributing employers or the union. These monies must be used for the exclusive benefit of plan participants and beneficiaries.

Guardian Nurses: A Shoulder You Can Lean On During Difficult Times

Understanding and making treatment decisions around a difficult medical diagnosis like cancer or MS or COPD can be a daunting task. Beginning September 1, members will have personal help from experts in dealing with such things. Guardian Nurses and Healthcare Advocates will work with you on a very personal level, even accompany you on visits with healthcare professionals to make sure you fully understand your diagnosis and all treatment options with the ultimate goal of helping you to make informed decisions about your care. Below is an example from Guardian Nurses case-notes detailing the type of intervention this group will be able to provide to our members.

A 36 year old union member who called his union office on Friday when, after having a routine MRI of his back, was told that the MRI showed a "significant finding of an 11cm mass on the right kidney." He was confused, did not know what his next step should be and asked for help. A nurse advocate reached out to him, reviewed his case by phone and facilitated an appointment within one week with a urologist at an academic medical center. Realizing that the appointment would be much more productive if he had a CT scan prior (but having no primary provider), she also arranged an appointment on Monday with a primary care physician who could order the CT and order blood work. She accompanied the patient to the appointment with the urologist and was there to support and interpret clinical information for him as he received a difficult diagnosis.

Please contact the Fund Office should a situation arise that would afford you an opportunity to take advantage of this very valuable service.

Coordination of Benefits (COB) Can Reduce Your Out-of-Pocket Costs

Some members may have benefit coverage from the Teamsters Local 830 Health & Welfare Fund and also their spouse's plan through another insurer. When this is the case, the patient can submit expenses under both plans to receive up to 100 percent coverage. This is called coordination of benefits. Please make sure to take advantage of this arrangement should it exist to reduce your out-of-pocket costs.

In the past, having two insurance plans may not have made sense, as your out-of-pocket costs were minimal. However, with the changes made to your health coverage this past September, you may wish to consider the following before deciding to enroll, or to opt out of coverage through your spouse's plan:

- Review the benefits you have with the Teamsters Local 830 Health & Welfare Fund.
- Review the benefits offered by your spouse's employer, including their coordination of benefits provisions.
- Weigh the cost of enrolling in your spouse's plan against the deductible and copays under your Local 830 plan.
- When considering the costs, it is important to remember that most employers' payroll deductions for health insurance are pre-tax while the money used to pay the deductible and copays is not.

If you need help deciding what makes the most sense for your situation, please contact the Fund Office.

FREE Support For Your Issues And Your Well-Being

Every person faces unique challenges in their lives. And every person deals with them differently. If you have medical coverage through the Teamsters Local 830 Health & Welfare Fund, then you have an Employee and Family Assistance Program (EFAP) included in your benefits package so that you don't have to go through it alone.

The Teamsters Local 830 Health & Welfare Fund has partnered with MH Consultants, a respected EFAP provider, to work with you or an eligible family member to identify the issue and map out a course of action to deal with the situation in the way you're most comfortable. From a crisis situation to day-to-day concerns, whether they're large or small, complex or simple, your Employee and Family Assistance Program helps you effectively manage work and life issues with complete confidentiality. You can feel secure knowing that no one, including your employer, will ever know who has used the service.

Resolve issues, feel better and prevent problems in the future through your Employee and Family Assistance Program.
Your first five visits are free. Additional services would be covered under Personal Choice as described in your benefit summary. Call MH Consultants at 800-255-3081 to get help now.

New Law Covering Dependent Children Effective September 1, 2011

There has been a lot of confusion concerning the effective date for the new healthcare reform provision requiring coverage of dependent children until age 26. In the case of the Teamsters Local 830 Health & Welfare Fund this coverage will become effective September 1, 2011, the first day of the first plan year that begins six months after enactment of the law (March 23, 2010). Under the new law, coverage will no longer be contingent on your child's student, marital or other dependency status. It is possible that the Fund will be able to exclude coverage for dependent children who are eligible to enroll under an employer plan other than the plan of the parent. More information on this will be provided as we approach the effective date of September 1, 2011.

Teamsters Local 830 Employee Benefit Funds
12298 Townsend Road—2nd Floor
Philadelphia, PA 19154

Telephone
Local: 215-969-1012
Toll Free: 800-782-5379

Office Hours
Monday through Friday
8:30 AM to 4:30 PM

Sam Kenish	**Fund Administrator**	**x3302**	**skenish@team830.org**
Lee Togneri	**Asst. Fund Administrator**	**x3306**	**ltogneri@team830.org**
Aggie Breen	Health & Welfare Claims Manager	x3304	abreen@team830.org
Joanne Creedon	Dental Senior Claims Manager	x3319	jcreedon@team830.org
Donna DiFrancesco	Vision/Life/AD&D/STD Senior Claims Rep	x3318	ddifrancesco@team830.org
Claire Dodd	Receptionist/Life/AD&D/STD Rep	x3301	cdodd@team830.org
Shirley Dustman	In-House Accountant	x3310	sdustman@team830.org
Diana Foschini	Rx Claims Rep/COBRA Rep	x3317	dfoschini@team830.org
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Jennifer Schmeltzer	Contribution Accounting Manager	x3314	jschmeltzer@team830.org
Lynn Valenti	Pension Claims Manager/Administrative Asst.	x3308	lvalenti@team830.org

VP Corner

...Glenn Fulcher

"Holiday Season"

This holiday season lets remember those who have served and are serving our country in the armed forces. It is important to remember that we need them to fight for us. Just as they need us to fight for them. We need to give thanks for those men and women for our fight for freedom.

More than two million union members are also veterans and like all workers, veterans are having a difficult time in this economy. Approximately eighteen percent are unemployed after returning from years of duty to find their jobs no longer waiting for them. Many are either homeless or living in shelters. America needs to strengthen and enforce veterans preference laws and work to make sure the veterans health administration is fully funded and staffed. No veteran should have to struggle to live a normal and healthy life.

America can give thank to two groups who are trying to make a better life for the rest of us: the armed forces and unions.

So this holiday season I say thanks to all those who have served their country in the armed forces and fight for our freedom overseas. I also say thanks to those who have served in the American Labor Movement who fought for our freedom on the home front.

Merry Christmas and a prosperous New Year to all our retirees, stewards and members.

Mastrome's Commentary

By: Tony Mastrome

Protecting Americas Workforce

Dr. Martin Luther King Jr. once said, "Injustice anywhere is a threat to justice everywhere."

More than forty years after Dr. King's passing the injustice to protecting the American workforce rages on and the threat of lax safety enforcement continues to infringe upon workers' rights.

Each year more than 5,000 American workers perish as a result of workplace safety violations, while another 4 million are seriously injured and thousands more will become ill as a result of occupational exposures.

The occupational Safety and Health Act affords us protections, but is it enough? Secretary of Labor Hilda Solis recently stated "No one regardless of his or her occupation should have to be injured or killed to earn a paycheck." I agree, but tell that to the families of the victims of workplace tragedies that occurred this past April.

On April 5th in Montcoal, West Virginia 29 coal miners perished as a result of an explosion. On April 20th the massive oil rig Deepwater Horizon exploded, killing 11 workers and injuring 17 others. Both tragedies due to violations of safety regulations were preventable.

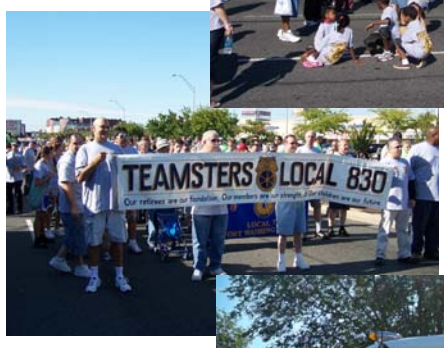
Its been 40 years since key provisions were updated to protect American Workers. We need legislation addressing safety concerns not covered by OSHA Act. Increasing civil and criminal penalties for safety violations and to enact laws protecting a workers right to refuse unsafe work. We need to provide family members of workers killed or incapacitated the right of being heard in OSHA investigations.

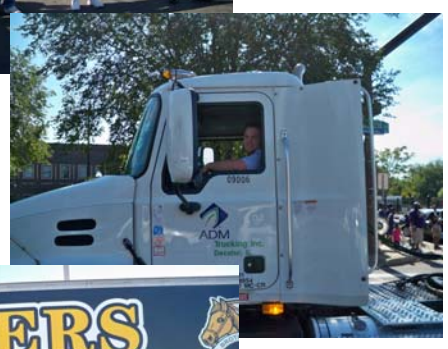
The loss of a loved one is horrific in itself, yet we seldom reflect on the endless suffering and anguish of the victims families that last a lifetime. Workers in all industries who work hard to earn a paycheck need to feel their employer is providing them with the highest standard of workplace safety.

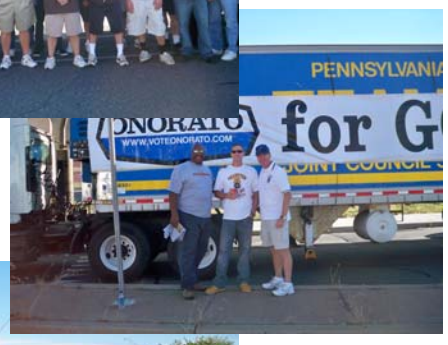
Every worker counts! Protect the American workforce.

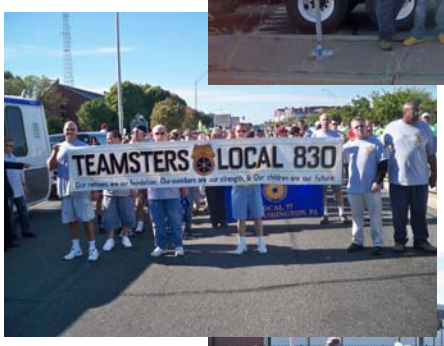
American Born! Teamster Sworn!

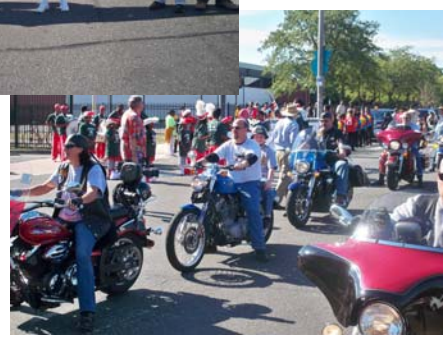
2010 Labor Day Parade











Warwick Twp. Employees

DECEASED

LOCAL 830 NOTES WITH SORROW THE PASSING OF THE FOLLOWING MEMBERS:

William Krause*	Sour Mash
Warren Losse*	SJ Laundry
William Austin*	Harry Ortlieb
Leslie Maxion*	Cott Beverage
Raymond Fogel*	Banko Beverage
Donald Cielinski*	Post Precision
Frank Safar*	Banko Beverage
Howard Magrann*	Schmidt's
Ronald Kondart*	Total Whse.
Oswald Schmid*	Local 1264
John Kennedy*	Modern Ldry
Walter Jones*	Vanguard/Pcmker
Felix Albano*	Fulton Bev.
Robert Knox*	Total Whse.
Jack P. Kluman*	Ortliebs Brwy
Jean Paff*	Total Whse.
Bruno Delmoro*	Penn Beer
Elmer Kline	Post Precision
John Palchick*	Coke Phila
Richard Dempsey*	Aramark
Lester Collier&	Havertown Bev.
Joseph Del Gesso	Pepsi Mays
John Lucas*	National Brands
Robert Dempsey*	ARA
Helen Finney*	Superior Dental
Leonard Stewart	Bunzl Phila
Anthony Massari*	Ortliebs Brwy
Leonard Swinick*	E.J. Poirier Dist.
Virgil Damore*	Gretz Bev.
Donald Zuerlein*	Coke Philly
Judith Galione*	Total Warehouse
Walter Czarnecki*	ARA
James Boorse	Coke Philly
Anthony Kosinsky Jr.*	Wm. HP
Dominick Cimabue Jr.*	Gretz Beer
Joseph Kerrigan*	Coke Philly
John Giaimo*	Mirabile Bev.
Wm. DePasquale*	Cattani Bev.
Ronald DiPietro*	Fulton Bev.
George Narr*	Schmidt's

*denotes Retiree

RETIRED

THE FOLLOWING MEMBERS HAVE ANNOUNCED THEIR RETIREMENT:

Raymond Harris III	TJU
John Engler	Pepsi Pennsauken
Richard Klawitter	Pepsi Mays
John Rupp	Pepsi Philly
Marvin Frack Jr.	Banko Bev.
James Miles	Coke Phila
Charles Schoffler	Coke Phila
Mark Salmonsen	Coke Phila
Daniel Santosusso Jr.	Local 830
Durell Hyden	Rt. Messengers
John Morris	Rt. Messengers
Thomas Deacon	Pepsi Phila
Robert Doms	Pepsi Pennsauken
Glenn Shoemaker	Pepsi Philly
Jim Ebinger	Pepsi Philly
Robert Wiegand	Coke Phila
Judy Miller	Post Precision
Lee Huber	Post Precision
Robert Schafer	Bunzl
Mahlon Hamm	Post Precision
Mary Glenn	Holiday Inn

WRITE IN'S

Dan,

I just wanted to send a quick note thanking you and the staff at Local 830 for your help in securing our new CBA. I would especially like to that our Business Agent, Glenn Fulcher. He worked really hard and committed his time and efforts to make sure the interests and concerns of our shop were addressed. Glenn was prepared and knowledgeable when we came to the table. As you know negotiating a contract at this time is not an easy task. We ended up with no concessions and pay raises along with additional gains.

Thank you,
Charles Young
Shop Steward, Hatboro Public Works

TEAMSTERS LOCAL 830
12298 Townsend Road
Philadelphia, PA 19154
(215) 671-9850

team830.org

team830.org

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Are you moving?

If so, let us know so that you don't miss an issue of the 830 REPORTER. Fill out this form with your new (or corrected) address, and give it to your Business Agent or mail it to:

Teamsters Local 830
12298 Townsend Road
Philadelphia, PA 19154

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

It's A Girl!

It's a girl for Local 830's Editor, Kristina Crawford. Chloe Noelle was born July 27th. Congratulations to Kristina, Shaun and Big Sister Mia Bella on their new edition!

2011 UNION MEETINGS...

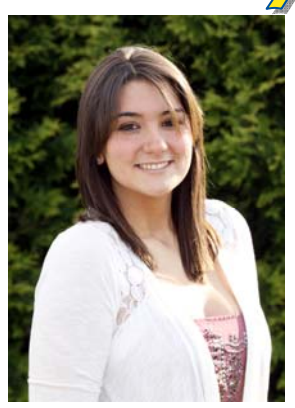
January 9, 2011—February 6, 2011—March 6, 2011—April 3, 2011
May 1, 2011 (We will vote to suspend meeting for June, July & August 2011 at this meeting.)

All meeting being at 10:00AM in the hall. Coffee & donuts are served!

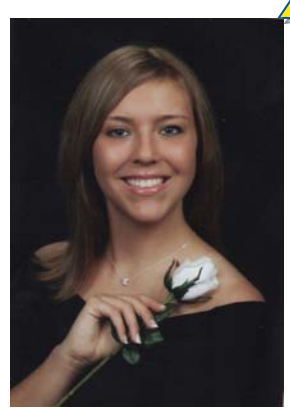
Teamsters Local 830 presents the 2010 Scholarship Recipients

Barbara Padlo
Parents: Michael & Irene
Philly Coke

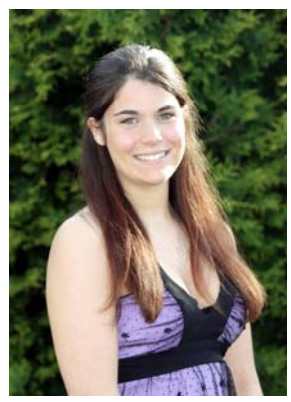
Jessica Pizzo
Parents: Robert Pizzo & Michele Ann Bartle
TJU



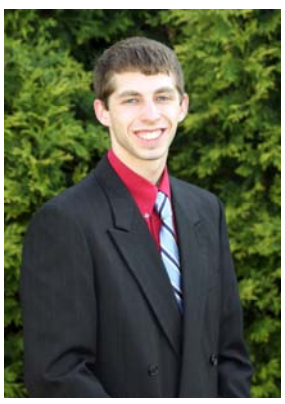
Victoria Talvacchia
Parents: Richard & Shawn
Origlio Beverage



Amanda Radovich
Parents: Richard & Heather
Pepsi Pennsauken



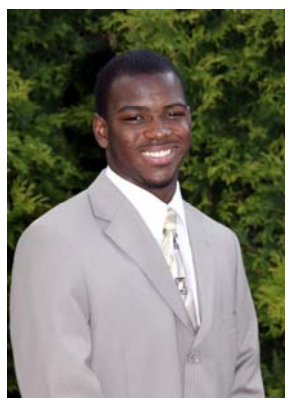
Kristen McCombs
Parents: Harry & Medeline
Canada Dry



Ryan Nasino
Parents: Gessie & JoAnn
Pepsi West Chester

Russell Rygalski III
Parents: Russell & Patricia
Philly Coke

Robert DeCarlo
Parents: Joseph & Sheryl
TJU



Isaac Gittens
Parents: Fitzgerald & Olivia
Philly Coke