FOR YOUR BENEFIT

THE NEWSLETTER OF THE LOCAL 295/851 EMPLOYER GROUP BENEFIT PLANS
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NOTICE TO ALL ACTIVE AND RETIRED PARTICIPANTS IN THE LOCAL 295/851 EMPLOYER GROUP WELFARE Because the Welfare Plan now requires retirees eligible to receive retiree medical coverage and participants eligible to receive the temporary extension of coverage to pay a monthly premium in order to receive coverage for themselves and/or their eligible dependents (other than dependent disabled children), the Welfare Plan has adopted procedures allowing retirees eligible to receive retiree medical coverage and participants eligible to receive the temporary extension of coverage to opt out of coverage and to reinstate coverage at a later date.

In order to be eligible for retiree medical coverage, you and/or your dependents must satisfy the Welfare Plan's eligibility requirements for such coverage as of the date you cease covered employment. If you elect to opt out of retiree medical coverage and wish to enroll (or re-enroll) at a later date, you and/or your dependents must also satisfy the applicable Plan eligibility requirements as of that date. In addition, you must timely pay the applicable premium in effect at that time and submit proof to the Plan that you and/or your dependents were covered by other substantially comparable medical coverage during the period that you and/or your dependents were not covered by the Plan (such as a certificate of creditable coverage). In the event that you choose to enroll (or re-enroll) on or after the date on which you and/or your dependents become eligible to receive Medicare benefits, you must provide evidence that you and/or your dependents were covered by Medicare and a plan supplementing Medicare benefits. Note that only you have the right to enroll and/or re-enroll on behalf of yourself and/or your dependents, and that your dependents do not have an independent right to enroll or re-enroll. Once you elect to opt out of retiree medical benefits on behalf of yourself and/or your spouse (either by providing the Welfare Plan with written notice of such election or by failing to timely pay applicable monthly premium payments), you and/or your spouse, as applicable, will no longer be eligible to receive death benefits under the Welfare Plan. Even if you and/or your spouse subsequently elect to enroll (or re-enroll) in retiree medical benefits, you and/or your spouse will not become eligible for death benefits under the Welfare Plan.

If you are eligible for a temporary extension of health coverage under the Plan, you also have the right to opt out of coverage and enroll (or re-enroll) at a later date. In order to do so, you and/or your eligible dependents must satisfy the Welfare Plan's eligibility requirements for such coverage as of the date you cease covered employment. If you opt out of the temporary extension of health coverage and wish to enroll (or re-enroll) at a later date, you and/or your dependents must also satisfy the applicable Plan eligibility requirements as of that date. In addition, you must timely pay the applicable premium in effect at that time and submit proof to the Plan that you and/or your dependents were covered by other substantially comparable medical coverage during the period that you and/or your dependents were not covered by the Plan (such as a certificate of creditable coverage). Note that even if you opt out of the temporary extension of health coverage for any period of time, the period for which you and/or your dependents are eligible for coverage will not be extended beyond the date that is the earliest of: (i) the date that you and/or your spouse, as applicable, reach age 65; (ii) the date on which you and/or your spouse, as applicable, become eligible for disability coverage under Medicare; (iii) the date that you return to covered employment; or (iv) the last day of the 24th month following the earliest date on which you could have begun receiving the temporary extension of health coverage, regardless of whether you elected to receive coverage at that time. Note that only you have the right to enroll and/or re-enroll on behalf of yourself and/or your dependents, and that your dependents do not have an independent right to enroll or re-enroll.

If you have opted out of retiree medical coverage or the temporary extension of health coverage and would like to enroll or re-enroll in such coverage,

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provided that you are eligible to do so, the earliest date on which you may begin receiving such coverage depends on the date on which the Fund office receives your premium payment and all applicable documentation. If received on or before the 15th day of the month, coverage may become effective as of the first day of the subsequent month. If received after the 15th day of the month, coverage may become effective as of the first day of the second month following the month in which the premium payment and applicable documentation are received.

This notice serves as a Summary of Material Modification describing the changes to the Welfare Plan which have been adopted by the Board of Trustees and modifies the Summary Plan Description for the Plan. This notice should be filed with your copy of the Summary Plan Description for the Plan. This notice provides only a brief explanation of the changes to the Plan. The Plan document, as interpreted by the Board of Trustees or its designee, controls in determining the rights of any Plan participant or beneficiary, and nothing in this notice is intended to change that.

The Board of Trustees, in its sole discretion, reserves the right to amend or terminate the Plan at any time, including but not limited to, the rights to change or discontinue benefits and to change contribution or copayment amounts or eligibility requirements.

The Board of Trustees has complete authority, in its sole and absolute discretion, to construe the terms of the Plan (and any related or underlying document or policies), and to determine the eligibility for, and amount of, benefits under the Plan. All such interpretations and determinations (including legal and factual determinations) of the Board of Trustees shall be final and binding upon all parties and persons affected thereby. Nothing contained herein is intended to provide you with any tax or financial advice. We urge you to consult with your independent tax and financial advisors in connection with your benefits.

If you have any questions about these changes, please contact the Fund Office. The Fund Office is located at Sixty Broad Street, 37th Floor, New York, New York 10004. The telephone number is (212) 308-4200.

The Fund Office hours are 9:00 A.M. to 5:00 P.M., Eastern Time, Monday through Friday, except for holidays. ■

GENERIC DRUGS: WHAT YOU NEED TO KNOW When the pain reliever acetaminophen was developed in the 1950s, it was only available under its brand name, Tylenol. Today, acetaminophen can be found in many generic and store-brand medicines. Many drug products, prescription and over-the-counter medicines have generic versions available. About 45% of prescriptions in the United States are filled with generic drugs.

New drugs are developed by innovator firms and patents protect these companies' investments by giving them the sole right to sell the drug while the patents are in effect. When patents are near expiration, manufacturers can apply to the Food and Drug Administration (FDA) to sell generic versions. The law that allows approval of generic products builds in certain protections for the original drug developer (including patents and marketing exclusivities), and it also allows drug sponsors of identical products to apply for FDA approval without repeating the original developer's clinical trials. The law also encourages generic firms to challenge innovator patents by awarding marketing exclusivity to the first generic version challenger. Generic drugs are safe, effective and FDA-approved, according to the director of the FDA's Office of Generic Drugs.

Here are some frequently asked questions about generic drugs and answers from the FDA:

Q: What are generic drugs?

A: A generic drug is a copy that is the same as a brand-name drug in safety and strength, how it is taken and its quality, performance and intended use.

Q: Are generic drugs as safe as brand-name drugs?

A: Yes. The FDA requires that all drugs be safe and effective. Since generics use the same active ingredients and are shown to work the same way in the body, they have the same risks and benefits as their brand-name counterparts.

Q: Are generic drugs as strong as brand-name drugs?

A: Yes. The FDA requires generic drugs to have the

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same quality, strength, purity and stability as brand-name drugs.

Q: Do generic drugs take longer to work in the body?

A: No. Generic drugs work in the same way and in the same amount of time as brand-name drugs.

Q: Why are generic drugs less expensive?

A: Generic drugs cost less because generic manufacturers don't have the costs of developing a new drug. New drugs are developed under patent protection. The patent protects the investment, including research, development, marketing, and promotion by giving the company the sole right to sell the drug while the patent is in effect.

Q: Are brand-name drugs made in more modern facilities than generic drugs?

A: No. Both brand-name and generic drug facilities must meet the same standards of good manufacturing practices. The FDA won't permit drugs to be made in substandard facilities. The FDA conducts 3,500 inspections a year to ensure standards are met. Generic firms have facilities comparable to those of brand-name firms. In fact, brand-name firms are linked to an estimated 50 percent of generic drug production. They frequently make copies of their own or other brand-name drugs but sell them without the brand name.

Q: If brand-name drugs and generics have the same active ingredients, why do they look different?

A: In the United States, trademark laws do not allow a generic drug to look exactly like the brand-name drug. However, a generic drug must duplicate the active ingredient. Colors, flavors, and certain other inactive ingredients may be different.

Q: Does every brand-name drug have a generic counterpart?

A: No. Brand-name drugs are generally given patent protection for years after the date of submission of the patent. This provides protection for the innovator who laid out the initial costs (including research, development, and marketing expenses) to develop the new drug. However, when the patent expires, other drug companies can introduce competitive generic versions, but only after they have been thoroughly tested by the manufacturer and approved by the FDA. ■

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

A federal law known as the Women's Health and Cancer Rights Act of 1998 (WHCRA) requires group health plans and insurance companies that provide coverage for mastectomies to provide certain mastectomy-related benefits or services to persons covered by the plan of benefits.

This Plan has historically provided the benefits required under the WHCRA and continues to make these benefits available to eligible persons. This notice is a brief overview of the benefits required under the WHCRA and your rights under the law.

Under the provisions of the WHCRA, a group health plan eligible person who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with the mastectomy is entitled to coverage for:

- all stages of reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of mastectomy, including lymph edema.

Coverage for these benefits or services will be provided in a manner determined in consultation with the eligible person's attending physician.

If you are eligible in the Plan and currently receiving, or in the future receive benefits under this Plan in connection with a mastectomy, you are entitled to coverage for the benefits and services described above in the event that you elect breast reconstruction. Your eligible dependents are also entitled to coverage for these benefits or services on the same terms.

Coverage for the mastectomy-related services or benefits required under the WHCRA will be subject to the same deductibles and coinsurance or co-payment provisions, if any, that apply to any other medical or surgical benefits provided under the terms of the Plan. ■

NEED INFORMATION? Call or visit the Fund Office. (212) 308 4200. The Fund Office is located in New York City at Sixty Broad Street, 37th Floor, New York, New York 10004. ■

THINKING ABOUT RETIREMENT? If you have been thinking about retirement, you should contact the Pension Fund Office well in advance of your targeted retirement date. You'll need to know the amount of monthly pension benefit you can expect to receive and the different types of pension that may be available to you. Also, if you have met the requirements to have your Welfare Fund coverage continue as a retiree, you'll need to know the cost of the coverage so that you can better plan your retirement.

You should also contact the Social Security Administration to find out how much you can expect to receive in monthly Social Security benefits on your targeted retirement date.

As of July 1, 2009 some of the benefits of the Local 295/Local 851 IBT Employer Group Pension Trust were reduced and some were eliminated. The changes were necessary as part of a rehabilitation plan that was required by the IRS and the Employee Retirement Income Security Act (ERISA).

Also, as of July 1, 2009 retirees have to pay a monthly premium to remain covered by the Local 295/Local 851 IBT Employer Group Welfare Fund. The premium rate is $200 per month for persons who are Medicare eligible and $300 per month for persons who are not Medicare eligible. You must decide in advance whether you want the coverage or not and then make arrangements for the payments.

Your estimated pension and Social Security benefits and premium cost together with an estimate of the income tax you may have to pay on pension and Social Security benefits can help you to decide if you should retire or continue working.

LOCAL 295/LOCAL 851 IBT EMPLOYER GROUP PENSION TRUST FUND AND EMPLOYER GROUP WELFARE FUND
SIXTY BROAD STREET
NEW YORK, NEW YORK 10004

Allow enough time in the benefit application process so that you don't experience a delay in the start of your benefit payments. Be sure to complete and promptly return all of the forms you receive from the Fund Office. For example, if you qualify for retiree health plan coverage, you will be asked to complete a form to either reject or accept the coverage. If the form isn't received by the Fund Office in time you could have a gap in your coverage that would be expensive to you if you incur any claims. ■

FULL-TIME STUDENT PROOF REQUIRED FOR EVERY SEMESTER

Dependent children are eligible Dependents in the Welfare Fund until December 31st of the calendar year in which they become age 19. Unmarried Dependent children over the age of 19 who attend an accredited school full time are eligible Dependents while they attend school full time, but not beyond December 31st of the calendar year in which they attain age 23.

If a dependent child is a full-time student, under the age of 23, coverage may be continued if you provide the Fund Office with a current original letter from the school registrar for each semester verifying the full-time student status of your son or daughter.

The coverage of all dependent students is terminated each semester unless the Fund Office receives a letter from the registrar's office that the dependent will be a full-time student for the next semester. This procedure is followed for every semester. The Fund Office cannot accept report cards, grade reports or tuition bills. ■